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APPLICATION FOR CARE

Today's Date _____

Welcome to our practice. Please answer the following questions. This will give the doctor valuable information needed to help you. Please be as accurate and complete as possible.

First Name: _____ Last Name: _____

Gender: ☐ M ☐ F Birthdate: ____ /____/_____ Age: _____ Height: _____ Weight: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Preferred contact method: ☐ Phone ☐ Text ☐ Email

Occupation: _____ Employer: _____ Work Phone: _____

Work Address: _____ City: _____ State: ____ Zip: _____

City _____ State _____ Zip Code ___

Marital Status: __ M __ S __ W __ D Spouse's Name: _____ # of Children: _____

Emergency Contact: _____ Phone: _____ ☐ H ☐ C ☐ W

Name and Address of Family Physician: _____

_____

Are you Medicare Eligible? ☐ Yes ☐ No

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)? ☐ Yes ☐ No

How did you hear about The Health and Wellness Center? _____

_____

CURRENT HEALTH CONDITION

Reason for today's visit (check all that apply):

☐ Allergy ☐ Pain ☐ Discomfort ☐ Stiffness ☐ Other _____

Describe what happened/what's going on: _____

_____

When did your complaint(s) first begin? _____

_____ Today, it is: ☐ Same ☐ Better ☐ Worse

Explain what helps and/or worsens the condition: _____

_____

Have you experienced this/these complaint(s) before? ☐ Yes ☐ No If yes, when? _____

_____

Are you pregnant? ☐ Yes ☐ No ☐ N/A if yes, how many weeks: _____

Other healthcare providers seen for this complaint: _____

_____

Their opinion/diagnosis? _____

What was done? _____

How have you managed your complaint on your own? _____

_____

Current prescriptions or Over-The-Counter medications? _____

_____

Current supplements/herbs taking? _____

When was the last time that you felt well? _____

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The Health & Wellness Center

PAST HEALTH HISTORY

Previous NAET care: ☐ Yes ☐ No Provider? _____

What were you treated for? _____

Has anyone else in your family had a similar problem? ☐ Yes ☐ No Who? _____

Are you allergic to any medication? ☐ Yes ☐ No What kind? _____

Check any of the following that applies to you:

☐ Allergies	☐ Bowel/Bladder	☐ Fibromyalgia	☐ High Blood Pressure	
☐ Arthritis	☐ Cancer	☐ Frequent Illnesses	☐ Migraines	☐ Stroke
☐ Asthma	☐ Chronic Fatigue	☐ Headaches	☐ Pacemaker	☐ Tumors
☐ Autoimmunity	☐ Diabetes – I or II	☐ Hepatitis – A/B/C	☐ Other: _____	

Are your allergies linked to:

☐ Foods (something eaten, ex. strawberries, milk, etc.) _____

☐ Environmental (ex. trees, dust, pollen, etc.) _____

☐ Chemicals (ex. odors, perfumes, etc.) _____

☐ Medications (ex. Prescription meds, vaccinations, flu shots, etc.) _____

How do your allergies affect your life? Check any of the following that applies to you:

☐ Weight loss / gain	☐ Stuffy nose	☐ Gas / Bloating
☐ Irritable	☐ Shortness of Breath	☐ Diarrhea
☐ Low energy	☐ Excessive thirst	☐ Heartburn
☐ Nervousness	☐ Frequent nausea	☐ Dizziness
☐ Fatigue	☐ Constipation	☐ Depression
☐ Poor sleep	☐ Hemorrhoids	☐ Forgetfulness
☐ Poor appetite	☐ Rashes	☐ Sinus Drainage/Pain
☐ Poor concentration	☐ Body/Joint Pain	☐ Other: _____

Check any of the following that applies to you:

☐ Breathing through the mouth	☐ Hearing breathing during rest
☐ Taking regular sighs	☐ Regular sniffing
☐ Irregular breathing	☐ Yawning with big breaths
☐ Get out of breath easily	☐ Upper chest breathing

Family Health History

☐ Allergies/Sensitivities	☐ Cancer	☐ Tumors	☐ Seizures	☐ Diabetes
☐ High Blood Pressure	☐ Heart Disease	☐ Stroke	☐ Autoimmune Issues	

Did You Know that traditional allergy testing has a 50-60% fail rate?	☐ Yes	☐ No
Did You Know that most food allergies manifest 24-48 hours after exposure?	☐ Yes	☐ No
Did You Know that medications are not a cure, they only mask the symptoms?	☐ Yes	☐ No
Did You Know that many allergies begin as a reaction to vitamins and minerals?	☐ Yes	☐ No
Did You Know that allergies can play a role in most diseases and illnesses?	☐ Yes	☐ No
Did You Know that allergies and sensitivities can also affect your ability to have a healthy and active lifestyle?	☐ Yes	☐ No

_____ _____

(Patient or Legal Guardian Signature (Date)

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INFORMED CONSENT AND TERMS OF ACCEPTANCE

EXPLANATION OF SERVICES

Nambudripad's Allergy Elimination Technique (NAET) is a mild, non-invasive method that helps to balance energies in the body. According to NAET theory, food and environmental sensitivities and true allergies can cause energy imbalances in the body. These energy imbalances are the primary cause for any sensitivity reaction towards any substance.

NAET treatments have been demonstrated to effectively manage the symptoms of a variety of allergies, including: food allergies, environmental allergies, animal allergies, etc. The systematic addressing of allergies through NAET can result in better function, more energy, improved immune response, and a healthier, more active lifestyle.

Side-effects to the NAET treatments are uncommon, yet can include **light headedness**, **nausea**, and **lack of energy**. They are usually associated with a low functioning immune system and resolve within 24 hours following the treatment.

NAET is not a primary healthcare procedure and does not diagnose disease. The Doctor(s) of The Health and Wellness Center do not claim to cure any illness or disease with NAET. While going through treatments, patients should try to keep their symptoms under control by taking necessary medications, therapies, acupuncture, chiropractic, massages or other therapeutic procedures. If the patient suffers from a specific health problem, he or she should also seek the care of an appropriate medical specialist to manage the health needs related to that condition.

Common alternatives to NAET services include inhalers, allergy shots, medications, avoidance diets, other medical treatments and surgery provided by physicians and surgeons.

WHAT WE DO

- We provide the public with a unique and affordable alternative approach to managing the symptoms associated with allergies/sensitivities often resulting in less symptoms, improved energy and increased health.
- We use Muscle Response Testing (MRT) to determine the patient's sensitivity towards allergens.

WHAT WE DON'T DO / LIMITATION OF SERVICES

- We do not offer to diagnose or treat any disease or condition other than the symptoms of allergies and sensitivities as addressed through Nambudripad's Allergy Elimination Technique (NAET).
- We do not administer skin scratch testing, skin patch testing, or blood draws to test for allergies.
- We do not accept or bill insurance, Medicare, and/or any third-party carrier for payment, except in the case of personal injury cases as the result of automobile accidents.

FINANCIAL RESPONSIBILITY

At the patient's discretion, payment options are available after the Doctor has established a treatment plan. All patients acknowledge that they are financially responsible to remit payment in full for all services provided to them. All patients further understand and agree that we will not submit any billing data or related claim(s) for, or on, their behalf to any private insurance program, Medicare or an Secondary Medicare Insurance Program carrier with whom they have insurance coverage.

By signing this Informed Consent, I acknowledge that I have discussed, or have had the opportunity to discuss, with my Doctor the nature and purpose of the NAET treatments, the benefits, risks and alternatives to NAET.

I consent to the NAET treatments offered or recommended to me. I understand that NAET and Muscle Response Testing is not considered to be a chiropractic service and is, therefore, considered to be an "unproven" procedure by the Colorado Board of Chiropractic. I intend this consent to apply to all my present and future NAET care received from The Health and Wellness Center.

I, _____ have read and fully understand the above statements.
(Patient Printed Name)

_____ _____ _____
(Patient Signature) (Date) (Witness Signature)

CONSENT TO EVALUATE AND TREAT A MINOR CHILD

I, _____ of _____ have read
(Parent or Legal Guardian) (Child(ren) Name)

and fully understand the terms of acceptance and hereby grant permission for my child(ren) to receive chiropractic care.

_____ _____
(Patient or Legal Guardian Signature) (Date)