NAET Patient Information

Date:_____

Name:_____

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

Date of Birth:__/__/____ Age:_____ Sex: M / F Height:_____ Weight:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____

Employer:_____ Occupation:_____

Employer's Address: _____

Driver's License #:_____ State:_____ Exp. Date __/__/____

Social Security #:_____ Marital Status: M/S/D/W # of Children: B__ G__

Name of Spouse: _____ Occupation:_____

Contact in Emergency: _____ Phone: _____

Medical Insurance: Y__ N__ Insurance Co. Name:_____

I.D.#_____ Name of Insured:_____

Consent to Treatment

I _____ hereby consent, authorize and request _____ to administer the treatment deemed advisable and necessary to my (my ward's) condition in accordance with his/her expertise. I agree to hold him/her free and harmless from any claims, suits for damages or complications which may result from such treatment.

Print Name:_____

Patient's Signature:_____ Date:_____

Witness Name:_____

Witness Signature:_____ Date:_____

Family History

Parents Living: Father (age)_____ Mother (age)____ Brothers_____ Sisters_____

Is there any fam. history of: Allergies:___ Diabetes:___ Hypoglycemia:___ Asthma:___

Cancer:___ Mental Disease:___ Lung Disease:___ Heart Disease:___ Skin Problem:___

Hypertension:___ Arthritis:___ Any other health problems?_____

Did your mother have: Gestational diabetes?___ Heavy metal toxicity?___ Mercury toxicity?___

Severe yeast infection?___ Do you have a relative with similar problems?___

Relationship_____ Was the mother on any drugs during the pregnancy?_____

List the Drugs:_____

The Center for Chiropractic & Holistic Care
25 East Afton Avenue
Yardley, PA 19067
215-321-0505

Did the mother use tobacco during pregnancy?___ Smoked cigarettes?___ Did the Child have a head injury during infancy?___ Before the age of three?_____ Fall____ Accidents____

Sudden fright for any reason? _____

Explain the above incident(s) if any in detail: _____

_____

Personal History

Childhood diseases: Measles: ___ Mumps:___ Chicken Pox:___

Unusual childhood diseases: _____

Immunizations: List and give names: _____

_____. Any severe reactions? _____.

Any severe reactions to other drugs? ___ Describe:_____

_____.

Are you taking any medications now? _____ List all names:_____

_____.

Any surgery? _____ Do you have ear tubes, or any other devices or aids (like shunts, hearing aids, pacemaker, etc.)?_____.

Do you take any vitamins? ___ List:_____.

Do you exercise? Y or N Regularly___ Infrequently____ Seldom___

Hobbies: _____.

List any known allergies: _____

_____

_____

_____.

Past History

List any previous significant injuries (slips, falls, auto accidents, etc.) and give the dates:

_____

_____

_____.

List any past significant illness and give the dates: _____

_____.

List all operations and give the dates: _____

_____.

Have you ever been to a chiropractor before? Y / N ? Date of last adjustment__/__/____

Name and address of your chiropractor: _____

_____.

Have you ever seen an acupuncturist? Y /N ? Date of last treatment __/__/____

When were you last seen by a physician? _____

For what purpose? _____.

Your current doctor's name and address: _____

_____.

Doctor's Phone #: _____

Date of Last Physical Exam: __/__/____

List all foods and beverages consumed more than three times a week:

_____

_____

_____.

If you suffer from exhaustion or fatigue, describe how you feel and what time of day or night you experience these symptoms, including whether they occur daily or occasionally.

_____

_____

_____

_____.

Do you suffer from any of these symptoms? (B= Before treatment, A= After NAET treatment)

___ ___	Arthritis	___ ___	Excessive Gas
___ ___	Headaches	___ ___	Insomnia
___ ___	Hot Flashes	___ ___	PMS
___ ___	Blurred Vision	___ ___	Poor Memory
___ ___	Dizziness	___ ___	Sexual Impotency
___ ___	Morning Fatigue	___ ___	Excessive Perspiration
___ ___	General Fatigue	___ ___	Palpitation of the Chest
___ ___	Labored Breathing	___ ___	Dry Skin
___ ___	Shortness of Breath	___ ___	Poor Appetite
___ ___	Indigestion	___ ___	Excessive appetite

___ ___ Heart Burn

___ ___ Lump in the Throat
___ ___ Throat Constriction
___ ___ Numbness
___ ___ Fainting Spell
___ ___ Light Headedness
___ ___ Swelling of the Joints
___ ___ Loose Stools
___ ___ Candida
___ ___ Pain Disorders

___ ___ Night Sweats

___ ___ Nerves
___ ___ Depression
___ ___ Learning Disabilities
___ ___ Asthma
___ ___ Chemical Sensitivities
___ ___ Constipation
___ ___ ADHD
___ ___ Autism
___ ___ Other

To Be Filled Out By Doctor/Physical Examination

Pulse: _____ Resp: _____ Blood Pressure: Sitting_____

General Appearance: _____

_____

_____.

X-Rays: What Part? _____ Date: __/__/____ Findings:_____

_____.

Lab Work?: _____.

Computer Evaluation?: Date: __/__/____ NST Evaluation Date: __/__/____

Findings: _____.

Diagnosis: _____.

Treatment Plan: _____.

Date of Discharge: __/__/____ Final diagnosis at Discharge: _____.

Name of Doctor: _____ Signature at Discharge:_____.

Patient's Signature: _____ Date: _____

Parent/ Guardian's Signature: _____ Date: _____

The Center for Chiropractic and Holistic Care – Dr. Levent Erdogan

I _____ certify that Dr. Levent Erdogan does not claim to cure any illness or disease with NAET (Nambudripad's Allergy Elimination Techniques). I understand that NAET is not a medical diagnostic procedure and therefore does not diagnose a disease. Rather, NAET gives the practitioner an indication as to the substance(s) to which the patient may have a sensitivity. NAET uses various, standard medically proven diagnostic measures and modalities (Allopathic, chiropractic, kinesiological, and acupuncture) to diagnose the patient's condition.

The premise behind NAET is to desensitize a patient to a substance(s) using allopathic, chiropractic, acupuncture/acupressure, nutritional, and kinesiological principles so that the patient may not experience hypersensitive symptoms when they have future contact with them. I understand that I am (my dependent) to continue all medications and other treatment modalities as they have prescribed unless otherwise directed by the doctor who prescribed them.

During the 25 hours or after if I (my dependent) get a life-threatening reaction from the allergen I (my dependent) was treated or from some other sources, I need to seek emergency help immediately from a physician qualified in emergency treatments, or by calling 911 or attending an emergency room at the local hospital.

If I (my dependent) am suffering from severe allergic reactions to substances, I should consult an appropriate physician and take appropriate medication (such as medication to prevent itching, tissue swelling, fever, cough, pains, infections, mental irritability, violent behaviors, etc.) to keep my (my dependent's) symptoms under control while I (my dependent) am treating with NAET treatments. This way essential NAET treatments can be completed without interruption and once I (my dependent) complete the essential NAET treatments for my (my dependent's) condition, I (my dependent) may not need to continue pharmaceutical drugs indefinitely.

I understand that for 25 hours after the treatment I (my dependent) am to avoid eating, touching, breathing, and coming within 5 feet or more as it was instructed by my practitioner of the substance(s) that I (my dependent) have received treatment.

If I (my dependent) come in contact with the substance(s) for which I (my dependent) am being treated, I realize that the treatment may not work and I (my dependent) may have a sensitivity reaction. I understand that I (my dependent) must return after my 25 hours avoidance period preferably within 7 days, to see if I (my dependent) have cleared for the substance(s).

I fully understand that I (my dependent) may still experience a reaction to the substance(s) of unknown severity if I (my dependent) come in contact with them if I (my dependent) did not clear them completely. If I (my dependent) did not clear them completely, I (my dependent) may require to repeat the procedure (more office visits at my cost) until I (my dependent) clear them satisfactorily.

After the successful completion of my NAET treatments I give permission to The Center for Chiropractic and Holistic Care 25 E. Afton Avenue, Yardley, PA 19067 to use my (my ward's) case study in educating other similar patients or accumulating data for research purpose without disclosing my real name or address.

I give permission to take photographs of my (my ward's) diseased body part (e.g. in case of skin problems, etc.) to use in research or patient purpose without disclosing my real name or address.

I have read or have had read to me the above statements and have had opportunity to ask questions about its content and by signing below I agree to the terms and procedures. _____ _____

Patient's Signature _____ Date_____

Name of the Minor _____

Relationship to the Ward/Minor _____

The Center for Chiropractic and Holistic Care

25 E. Afton Avenue Suite C

Yardley, PA 19067

HEALTH CARE AUTHORIZATION FORM (HIPPA)

Patient's Name: _____ **Date:** _____

Patient's SS# _____ **Date of Birth:** _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES: **The Center for Chiropractic and Holistic Care, TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:**

☐ I give permission to **The Center for Chiropractic and Holistic Care** to use my address, phone number and clinical records to contact me with my appointment reminders, missed appointment notification birthday cards, holiday related information.

If **The Center for Chiropractic and Holistic Care** contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.

I give The Center for Chiropractic and Holistic Care permission to treat me in a n open room where other patients are also being treated. Should I need to speak with the doctor at any time in private, the doctor will provide a private room for these conversations.

*By signing this form you are giving **The Center for Chiropractic and Holistic Care 25 E. Afton Ave, Yardley PA 19067** permission to use and disclose your protected health information in accordance with the directives listed above.*

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke the AUTHORIZATION, in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action I reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **The Center for Chiropractic and Holistic Care.** This written notice must contain the following information:

Your name, Social Security number and date of birth, clear statement of our intent to revoke the AUTHORIZATION, the date of the request and your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by **The Center for Chiropractic and Holistic Care** for its own use/disclosure of PHI. (Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **The Center for Chiropractic and Holistic Care will not refuse to provide treatment.**

You have the right to inspect or copy the PHI to be used/disclosed.

Print Name: _____ **Signature:** _____

Signature of Personal Representative/Guardian/Parent: _____

Description of Representative's Authority To Act for Patient: _____