PATIENT INFORMATION

Name ______________________________________ Today's Date ________________

Date of Birth ________________ Height ______ Weight _____ Dominant Hand? R L

Address ____ City ______________ Zip ________

Phone (cell) _________________________ Phone (Home) __________________________

Phone (Work) ________________________ email __________________________________

SS # ________-______-_________ DL# ____

Check one: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Children:______ Ages: ____

Complains 1. ____

2. ____

3. ____

Name of your Personal M.D. _____________________________ Phone ____________________

Address ______________________________________ City __________________ Zip ________

Other Doctors had seen For This Condition: ☐ Yes ☐ No Who? _____________________

Type of Treatment: _________________________ Results: ____________________________

When Did This condition Begin? _______________ Occurred Before? ☐ Yes ☐ No

Is Condition ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____________

Date of Accident: ______________________ Time of Accident: _________________________

Any Medication you are taking: ____

Do you wear a shoe lift? ☐ Yes ☐ No size: which leg: ☐ Left ☐ Right

Do your suffer from any condition other than that which you are now consulting us?

____

Major Surgery/operation: ____

Broken Bones: ____

Major Accident or falls: ____

Hospitalization: ____

Previous Kinesiology Care:____

NAET Allergy Symptom Rating Scale

Rate symptoms on a “0” to “10” scale, where “0” no problem “10” Severe

Symptoms Discomfort Rating On a “0 to 10” Scale

[ ] Abdominal Bloating	[ ] Dermatitis	[ ] Itchy throat
[ ] Abdominal Pains	[ ] Depression	[ ] Joint pains
[ ] Achy feet/restless leg syndrome	[ ] Diarrhea	[ ] Moodswing
[ ] Acne	[ ] Drowsy after meals	[ ] Nervousness
[ ] ADHD	[ ] Eczema	[ ] Poor wt gain
[ ] Anger	[ ] Fatigue	[ ] Seizures
[ ] Asthma	[ ] Fever	[ ] Sinusitis
[ ] Autism	[ ] Flatulence	[ ] Skin rashes
[ ] Backache	[ ] Headache	[ ] Thirst
[ ] Bodyaches	[ ] High bloodpressure [ ]] Hives	[ ] Throat swelling
[ ] Cankersores	[ ] Indigestion	[ ] Throat close
[ ] Constipation	[ ] Insomnia	[ ] Weight gain ________
[ ] Cough	[ ] Itchy eyes	

What are you allergic too

Metabolic function	Food	Environmental
Vitamins ____________________ Minerals____________________ Sugar____________________ Protein____________________ Oil ____________________	______________________ ______________________ ______________________ ______________________ ______________________ ______________________ ______________________	______________________ ______________________ ______________________ ______________________ ______________________ ______________________ ______________________

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE

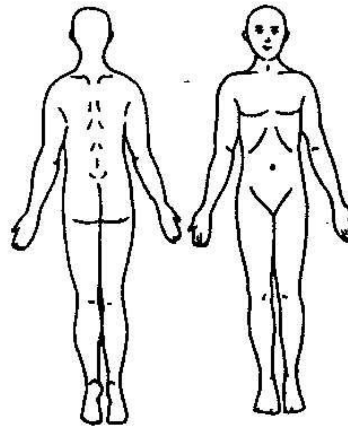
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________

FEMALES ONLY:

When was your last period?______

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

____
Doctor's Signature

CONSENT FORM

I ____ certify that Dr. Aaron Orpelli does not claim to cure any illness or disease with AK® NAET® NET®.

I understand that AK, NET, NAET, are not a medical diagnostic procedure and therefore do not diagnose a disease. Rather, AK® using muscle testing as functional neurological evaluation. NAET® gives the practitioner an indication as to the substance(s) to which the patient may have sensitivity. NAET® uses various standard medically proven diagnostic measures and modalities (Allopathic, chiropractic, kinesiology, and acupuncture) to diagnose the patient's condition. The premise behind NAET® is to balance the energy of the individual patient to a substance(s) using NAET® (this procedure uses information from allopathic, chiropractic, acupuncture/acupressure, nutritional, and AK) so that the patient may not experience hypersensitive symptoms when they have future contact with them. AK a science of applied neurophysiologic diagnosis based on the function of the nervous system: irritation of the nervous system by mechanical, chemical, or psychic factors is the cause of disease; restoration and maintenance of health depend on normal function of the nervous system NET methodology of finding and removing neurological imbalances related to physiology or unresolved stress patterns. We call these patterns **Neuro Emotional Complexes**.

I understand that I am (my dependent) to continue all medications and other treatment modalities as they have been 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 given NAET® EBP earlier or from some other sources, I need to seek emergency help immediately from a physician qualified in emergency care, 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, asthma, cough, pains, infections, mental irritability, violent behaviors, etc.) to keep my (my dependent's) symptoms under control while I (my dependent) am going through NAET® energy balancing procedures (EBP). This way NAET® EBP program can be satisfactorily completed on the basic allergens without interruption and once I (my dependent) complete NAET® EBP for- my (my dependent's) condition, I (my dependent) may experience reduction of my allergic symptoms and improved quality of life. I understand that for 25 hours after the NAET® EBP, 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 EBP for. If I (my dependent) come in contact with the substance(s) for which I (my dependent) am being energy balanced, I realize that the EBP 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 24 hours but at least within 7 days, to determine 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 repeating the procedure (more office visits at my cost) until I (my dependent) clear them satisfactorily. After the successful completion of my NAET® EBP program I give permission to the Dr. Aaron Orpelli 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 photograph of my (my ward's) diseased body part (e.g. in case of skin problem, etc.) to use in research or patient education purpose without disclosing my real name or address.

I have read or have had read to me the above statements and have had the 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 (mother/father/guardian/husband/wife)

_________________________   __________________

Signature of Witness   Date