NEW PATIENT HISTORY FORM

Perry Wolk-Weiss, DC
The Get Well Center
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Name_____Date_____File No._____
Phone number_____Email_____
Home address_____City_____State_____Zip_____
Date of birth_____Age_____Sex M___F___ Height_____ Weight _____
Employer_____Occupation_____Work phone _____
Work address_____City_____State_____Zip_____
Driver's License #_____State_____Exp Date_____
Marrital status M S D W No. of children _____ Boys___ Girls____ S.S.#_____
Name of spouse_____Referred by_____
Spouse's employer_____Spouse's occupation_____

If patient is a child, please fill out above work information for parent, or whoever is financially responsible.

Medical Insurance: Yes____No_____ Insurance Co. Name_____

Each insurance plan varies as to coverage. We will be happy to verify your particular insurance plan benefits. Once we determine if you are a candidate for NAET we will discuss your financial options.

What is your main problem? How long have you had this problem? Please describe in detail.
What do you believe caused this condition?
What are your health goals?

List your medical problems in order of severity and describe any past treatments.
What medications do you take? Please list all medications (prescription and over the counter), vitamins, and herbal supplements. Include doses if you know them.
What foods allergies or sensitivities do you have? Please describe the reaction as well.
What medication allergies or sensitivities do you have? Please describe the reaction as well.
What environmental allergies do you have? Please describe the reaction as well.

Have you ever had an anaphylactic reaction? Yes_____ No_____. If yes, please describe the situation.
What surgeries have you had? Please include the dates or your age at the time of surgery.
Have you ever been hospitalized? For what reason?
Describe any childhood illnesses (for example - childhood asthma).
Have you had any physical injuries from accidents such as falls, auto accidents, etc?
Do you have any mechanical devices in your body, like shunts, hearing aids, pacemaker, ear tubes, implants, etc?
Do you currently smoke? Yes_____No_____. If yes, how many cigarettes per day? _____ Have you ever smoked in the past? Yes_____No_____. If yes, for how many years_____ Do you drink alcohol? Yes_____No_____. If yes, how much and how often?_____ Have you ever used marijuana?_____ Have you ever used other drugs like cocaine, heroin, amphetamines, etc?_____
Please describe any past and present life stressors. For example, include any traumatic events, stress from relationships, stress from work, and financial hardships.
How do you relax? What are your hobbies?
Do you exercise? Yes_____No_____ How often? Regularly_____Infrequently_____Seldom_____ What type of exercise?

Regarding your diet:

- ❑ I have no dietary restrictions.
- ❑ I am vegetarian.
- ❑ I am vegan.
- ❑ I follow a gluten-free diet.
- ❑ I avoid certain foods. Please list the foods you avoid:_____
  _____

What is your current weight?_____ What is your goal weight?_____

Please describe your typical breakfast, lunch, dinner, snacks, and choice of beverages:

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

Who is your primary care doctor?
Office location:
When was your last physical exam?

List your other doctors and health care providers (specialists, acupuncturists, chiropractors, etc).

Health Maintenance Issues	
When was your last: Colonoscopy_____ Flu shot_____ Tetanus shot_____ Cholesterol checked_____ General blood tests_____	For Women: When was your last: Mammogram_____ PAP Smear_____ Last menstrual period_____ Are you pregnant now? Yes____No____

Do you have a history of any of the following illnesses?
Chicken pox____Measles_____Mumps_____Rubella_____Scarlet fever_____Polio_____TB____

Family History:

Please tell us if your family members have had heart disease, cancer (specify type), diabetes, allergies, autoimmune disease (specify type), lung disease, skin issues, hormonal issues, heavy metal toxicity, or any other health issues.

Mother's age_____Health problems_____
Father's age_____Health problems_____
Sibling's age_____Health problems_____
Sibling's age_____Health problems_____
Sibling's age_____Health problems_____
Sibling's age_____Health problems_____

Are you aware of any issues in your mother's health while she was pregnant with you, including medications, illnesses, and diagnoses?

Did your mother smoke or use drugs during pregnancy?

Have you ever experienced an adverse reaction to an immunization? Please describe.

For Pediatric patients:
List all immunizations received with dates (or attach copy of immunization record):

Please elaborate on anything else you feel is important for your doctors to know in order to provide the best care.

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Please check off any of the symptoms below you have had in the past six months to a year.

General
- ❑ Weight loss
- ❑ Weight gain
- ❑ Fatigue
- ❑ Fever
- ❑ Chills
- ❑ Weakness
- ❑ Trouble sleeping

Skin
- ❑ Hives
- ❑ Eczema
- ❑ Psoriasis
- ❑ Other rash
- ❑ Lumps
- ❑ Acne
- ❑ Itching
- ❑ Dry skin
- ❑ Color changes in skin
- ❑ Hair loss
- ❑ Abnormal hair growth
- ❑ Premature graying
- ❑ Dandruff
- ❑ Nail changes

Head, Ears, Nose
- ❑ Headaches
- ❑ Head injury
- ❑ Sensitivity to light
- ❑ Sensitivity to sounds
- ❑ Decreased hearing
- ❑ Ringing in the ears (tinnitus)
- ❑ Earache
- ❑ Ear drainage
- ❑ Problems with vision
- ❑ Watery or itchy eyes
- ❑ Floaters in vision
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Nasal congestion
- ❑ Postnasal drip
- ❑ Nose bleeds
- ❑ Sinus pain or infections
- ❑ Sneezing
- ❑ Dry mouth
- ❑ Hoarseness
- ❑ Thrush
- ❑ Mouth sores
- ❑ Bad breath
- ❑ Dental decay
- ❑ Bleeding gums
- ❑ Gum disease
- ❑ Sore throat
- ❑ Hoarseness

Neck Symptoms
- ❑ Lumps in neck
- ❑ Swollen glands
- ❑ Pain in neck
- ❑ Stiffness in neck

Breasts
- ❑ Breast lumps
- ❑ Breast pain
- ❑ Breast discharge

Lungs
- ❑ Asthma
- ❑ Dry cough
- ❑ Productive cough
- ❑ Coughing up blood
- ❑ Shortness of breath at rest
- ❑ Wheezing
- ❑ Painful breathing

Heart
- ❑ Chest pain or discomfort
- ❑ Chest tightness
- ❑ Irregular heart beat
- ❑ Shortness of breath with activity
- ❑ Difficulty breathing when lying down
- ❑ Swelling in legs
- ❑ Sudden awakening from sleep with shortness of breath
- ❑ High blood pressure
- ❑ Low blood pressure

GI tract
- ❑ Difficulty swallowing
- ❑ Heartburn
- ❑ Increased appetite
- ❑ Decreased appetite
- ❑ Nausea
- ❑ Vomiting
- ❑ Constipation
- ❑ Diarrhea
- ❑ Blood in stools
- ❑ Yellow skin or eyes
- ❑ Abdominal pain
- ❑ Bloating
- ❑ Hemorrhoids

Urinary Tract
- ❑ Frequent urination
- ❑ Burning with urination
- ❑ Incontinence
- ❑ Blood in the urine
- ❑ Prostate abnormalities

Reproductive
- ❑ Vaginal or penile discharge
- ❑ Sores in genital region
- ❑ Sexually transmitted diseases
- ❑ Yeast infection
- ❑ Pain with intercourse
- ❑ Decreased libido
- ❑ PMS (premenstrual syndrome)
- ❑ Infertility
- ❑ Irregular menses
- ❑ Heavy menses
- ❑ Painful menses

Vascular
- ❑ Calf pain when walking
- ❑ Leg cramping
- ❑ Varicose veins

Musculoskeletal
- ❑ Muscle pain
- ❑ Joint pain
- ❑ Stiffness
- ❑ Back pain
- ❑ Swelling of joints
- ❑ Injury to joints
- ❑ Redness of joints
- ❑ Hip pain
- ❑ Knee pain
- ❑ Shoulder pain

Neurologic
- ❑ Dizziness
- ❑ Fainting
- ❑ Seizures
- ❑ Weakness
- ❑ Numbness
- ❑ Tingling
- ❑ Tremor
- ❑ Migraine headaches
- ❑ Brain fog
- ❑ Daytime drowsiness

Hematologic
- ❑ Anemia
- ❑ Easy bruising
- ❑ Cuts heal slowly
- ❑ Bleeding problem

Hormonal
- ❑ Intolerance to heat
- ❑ Intolerance to cold
- ❑ Frequent urination
- ❑ Excess thirst
- ❑ Hot flashes

Mental Health
- ❑ Depression
- ❑ Anxiety
- ❑ Memory loss
- ❑ Suicidal thoughts
- ❑ Bipolar disorder
- ❑ Attention deficit
- ❑ Anger outbursts
- ❑ Compulsive behavior
- ❑ Emotional imbalances
- ❑ Hyperactive
- ❑ Phobias

Other
- ❑ Craving for sweets
- ❑ Craving for salty food
- ❑ Craving for spices
- ❑ Crave coffee or caffeine
- ❑ Crave sour or bitter

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I _____certify that Dr. Perry Wolk-Weiss 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 subtance(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 balance the energy of the individual patient to a substance(s) using NAET® (this procedure uses information from allopathic, chiropractic, acupuncture/acupressure, nutritional, and applied kinesiology) so that the patient may not experience hypersensitive symptoms when they have future contact with them.

I also understand that I am fully responsible financially for all services and authorize the above doctor to evaluate me to determine if I am a candidate for this type of treatment.

Patient's Name:_____

Patient's Signature:_____Date:_____

Guardian's Signature if Minor:_____