Lifelong Health and Weight Loss

NAET Client Case Record

Today's Date ____________________ **Social Security #** ____________________

Last Name ____________________ **First Name** ____________________

Date of Birth:____________________ **Age**__________ **Sex: Male/ Female**

Address:____________________ **City** ______________**State**_______**Zip**________

Phone (W)____________________ **(C)**____________________ **(H)**____________________

Email:____________________ **Occupation**____________________

Please list your five main physical complaints in order of importance:

1.____________________

2.____________________

3.____________________

4.____________________

5.____________________

What type of treatment are you currently receiving:____________________

____

List and medications that you are presently taking:____________________

History of major illness/ operation/ treatment:____________________

____

Known allergies:____________________

Anaphylactic Allergies____________________

List any nutritional supplements you are taking:____________________

Doctor Notes:

Family Illnesses:

Father: ____

Mother: ____

Grandmother: ____

Grandfather: ____

Brothers: ____

Sisters: ____

What foods do you crave? ____

What is your present weight? _________**What is your ideal weight?** _____________________

What time of day are you most tired? ______________________

Do you get depressed, worry, lack of concentration, memory problems? Please explain____

____

If you are a woman, please explain any difficulties with your cycle or hormonal concerns

____

Please write down the major types of infections or illnesses you have had during your life, even as a child and roughly at what age ____

____

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Doctor Notes