Allen Chiropractic Care
Dr. Troy Allen
43 N 300 W Suite B Washington, UT 84780 Phone: 435-986-1021 Fax: 435-986-1041

NEW PATIENT HISTORY FORM - (Please print legibly)

Name____ Phone ( )______________________________
Address________________________________ City______________________State_______ Zip___________
Date of Birth__________________Age_________Sex: M ____F ___Height ___________Weight___________
Employer___________________________________ Occupation _______________________________________
Marital Status M S D W No. of Children: [ ] Boys_________________Girls___________________
Name of Spouse ______________________________ Spouse's Occupation__________________
Person financially responsible (if patient is a child, fill out above work information etc., for patient, if he/she is a minor.____
Contact in Emergency _______________________ Relationship _______________ Phone_______________
Referred by ____

Payment is Due at the Time of Service. Cash pay only. No insurance accepted.

Signed: ____ Date______________________

Initial Visit: $75 Next Treatment: $60 Next Treatment + Combo W/ BBF of Prev Treatment $90

Personal History:

Childhood diseases: Measles _____Mumps _____Chickenpox ______Stept Throat ______Mono _______
List any other unusual or significant illness. ____
List any previous significant injuries (slips, falls, auto accidents, etc.) and give dates.
____
Any unusual events happened in your childhood, or later? ______________________________________
Describe the situation. ____
Any surgery? ____
Are you taking any medications currently? Yes [ ] No[ ] List all names ___________________________
____
Any severe reactions to any meds? ______________Describe _____________________________________
Do you take any vitamins? List names ____
Do you take any Recre Drugs? _____List names____
Any devices or aids (like shunts, hearing aids, pacemaker, etc.)_________________________________
Do you exercise? _____________Regularly__________Infrequently____________Seldom _____________
Hobbies if any____
Have you seen any chiropractor before? Yes[ ] No [ ] Last adjustment ___________________________
List any known allergies ____
Past Allergy test. Date ___________ Please bring in a copy of previous results if available.
PAST NAET Treatments ____
: please bring in a copy of the items treated.
If you suffer from exhaustion or fatigue, describe in your own words how you feel and what time of day or night you experience these symptoms, including whether they occur daily, occasionally, etc.
____
Any History of severe allergic reaction or Anaphylaxis? Yes [ ] No [ ]
If Yes, list the items. ____
List the dates, place, and on the item (s) you had anaphylaxis. _____________________________________
How did you handle the reaction? ____
Explain____
Any other problems not listed above ____

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Family History

Place/country where the patient was born ______________________________
Place lived until 5 years old ______________________________
Parents living or age at death: father (age)______________Mother (age)______________
Grandfather(f) ______________ Grand mother(f) ______________
Grandfather(m) ______________Grand mother(m) ______________
Grt-grandfather(f) ______________ Grt-grand mother(f) ______________
Grt-grandfather(m) ______________ Grt-grand mother(m) ______________
Brothers______________Sisters______________
First cousins______________________________
Is there any family history of: (specify who in the family has it or had it)
Diabetes (who in the family) ______________________________
Alcoholism (who in the family) ______________________________
Asthma (Who in the family) ______________________________
Arthritis (who/what kind) ______________________________
Cancer (who/what kind) ______________________________
Mental disease (who/what kind) ______________________________
Migraines (Who in the family) ______________________________
Heart disease (who/What kind) ______________________________
Lung disease (who/what kind) ______________________________
Kidney disease (who/what kind) ______________________________
Allergies (who/what kind) ______________________________
Any specific Infections (Who/what kind) ______________________________
Any other rare disease (who/what kind) (specify) ______________________________
Did your mother have gestational diabetes? ______________________________
Heavy metal toxicity? __________Mercury toxicity? __________Severe Yeast Infection? __________
Gluten Sensitivity? ______________ Do you have a relative with a similar problem? ______________
Was the mother on any drugs during pregnancy? Yes [ ] No [ ] During Childbirth ______________
After Childbirth ______________Name the drug(s) ______________
Did the mother use Tobacco during pregnancy? ________Smoked Cigarettes?________ Alcohol________
Did the child have a head injury during infancy or childhood? ________Fall ________Accidents ________
Sudden fright for any reason? ______________________________
Explain the above incident(s) if any in detail: ______________________________

Chief Complaint:

Describe present complaint fully ______________________________
Duration of present condition ______________________________
What do you believe caused this condition? ______________________________
Is your condition due to an accident? Yes [ ] No [ ] Explain ______________________________
If due to auto accident or injury at work, please specify ______________________________
Illness? Yes [ ] No [ ] If Illness please explain. ______________________________
When were you last seen by a physician? ______________ For what purpose?______________
____
Your current doctor's name ______________Specialty______________
List all foods and beverages taken more than three times a week
____
____
____

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Number the boxes which apply to you with a 1, 2, or 3. (1) for mild symptoms (2) for moderate symptoms (3) for severe symptoms. Leave the box blank if it doesn't apply to you.

Symptoms	1	2	3		Symptoms	1	2	3
Abnormal appetite poor/excess					Coated tongue			
Abdominal bloating					Cold sweats often			
Absent mindedness					Colds/flus frequent			
Abnormal hair growth					Colitis			
Acid foods upset					Compulsive behavior			
Acne					Constipation			
Addiction to smoke					Cold extremities			
Addiction to sugar					Cough			
Addiction to alcohol					Cradle cap			
Addiction to drug					Crave spices			
Allergic to drugs					Crave salt			
Addiction to spices					Crave sweets			
Anemia					Crave sour / bitters			
Anger					Crave onions/ beans			
Appetite -excess					Chronic Fatigue			
Arthritis					Cuts heal slowly			
Asthma bronchial					Dandruff			
Asthma cardiac					Decreased sex drive			
Athlete's foot					Depression			
Bad breath					Diabetes			
Backache - (upper area)					Diarrhea			
Backache (middle area)					difficulty in walking			
Backache (Lower area)					Difficulty in swallowing			
Blurred vision					Digestion rapid			
Bowel disorders					Diverticulitis			
Brain fog					Dream disturbed sleep			
Breast pain or swelling					Dry nose			
Breast lumps					Dry eyes			
Bronchitis					Dry mouth			
Brown spots					Dyslexia			
Bruises easily					Ear aches			
Burning/ itching anus					Ear infection			
Burning feet					Eating disorder			

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(1) for mild symptoms (2) for moderate symptoms (3) for severe symptoms, Leave the box blank if it doesn't apply to you.

Symptoms	1	2	3
Eczema			
Edema			
Emotional imbalances			
Elbow pains			
Excess thirst			
Eyelids puffy			
Eyes watery			
Eyes itch			
Fainting spells			
Falling hair			
Fatigue			
Feels cold often			
Feels insecure			
Fever			
Fibromyalgia or body ache			
Forgetfulness			
Frequent rashes			
Gags easily			
Gallstones			
Gastric distress			
General itching			
Greasy foods upset			
Hair loss			
Hay fever			
Headaches/sinus			
Headache/morning			
Headache/afternoon			
Headaches - migraine			
Hearing decreased			
Heartburn			
Heart irregularities			
Hemorrhoids			
Herpes			
High altitude causes problems			
High blood pressure			

Symptoms	1	2	3
Hip pains			
Hives			
Hoarseness			
Humidity-discomfort			
Hungry between meals			
Hyperactivity			
Hysterectomy			
Ileocecal valve			
Increased sex drive			
Indigestion			
Infertility male/female			
Insomnia			
Internal trembling			
Irritable and restless			
keyed-up and fails to calm			
Knee pains			
Labored breathing			
Low Back ache			
Low blood pressure			
Lump in the throat			
Memory loss-long term			
Memory loss-short-term			
Menses, scanty			
Menses, excess			
Menses, irregular			
Menses, Painful			
Mental confusion			
Metallic taste			
Migrating pains			
Milk causes discomfort			
Mood swings			
Mucus production			
Muscle cramps or spasms			
Nasal polyp			
Nausea or vomiting			

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(1) for mild symptoms (2) for moderate symptoms (3) for severe symptoms, Leave the box blank if it doesn't apply to you.

Symptoms	**1**	**2**	**3**		**Symptoms**	**1**	**2**	**3**
Neck pains					Sleepy during the day			
Nervous stomach					Slow pulse < 65			
Neuralgia					Slow starter			
Night sweats					Smell decreased			
Nose bleed					Sneezing attacks			
Numbness					Sore throat			
Obsessive behavior					Sore canker			
Ovarian cyst					Sour stomach			
Pain between shoulders					Startles easily			
Pain on the heels					Strong light irritates			
Pain-unexplained					Swollen ankles and feet			
Pain - shoulder					Thinning / thickening of the skin			
Perspiration excess					Throat constriction/throat closing			
Phobias					Tightness in the chest			
PMS (premenstrual symptom)					Tingling sensation all over the body			
Poor memory					Tires too easily			
Post nasal drip					Tourette's Syndrome			
Premature graying					Urinary tract disorder			
Prolapse uterus or bladder					Urination difficult			
Prone to infections					Urine amount increased /decreased			
Prostate trouble					Uterine polyp			
Psoriasis					Vaginal discharge			
Red or Pink eyes					Varicose veins			
Restless leg syndrome					Warts			
Ringworm					Weak nails			
Ringing in the ears					Weight gain			
Seizures					Weight loss			
Sensitive to cold /heat					White spots over the body			
Shortness of breath					Worrier			
Shoulder pains					Yeast infection			
Sighs frequently					List Other Conditions if any			
Sinusitis					Other Conditions			
Skin problems					Other Conditions			

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PATIENT'S CONSENT FORM

I ____________________________________, certify that Dr. Allen 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, nutritional, kinesiological, and acupuncture disciplines) 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 above mentioned disciplines) so that the patient may not experience hypersensitive symptoms when they have future contact with these desensitized substances.

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 of NAET® desensitization procedures, if I (my dependent) get a life-threatening reaction from the allergen, I (my dependent) was desensitized (or my ward) through NAET earlier or the reaction happened from some other source, I need to seek emergency help immediately from a physician qualified in emergency care, or by calling 911 in USA 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® procedures. This way the NAET® program can be satisfactorily completed on the basic allergens without interruption and once I (my dependent) complete NAET® for my (my dependent's) sensitivities, I (my dependent) may experience reduction of my allergic symptoms and improved quality of life.

I understand that for 25 hours after the NAET®, I (my dependent) am to avoid eating, touching, breathing and coming within 5 feet or more as I was instructed by my practitioner for the substance(s) that I (my dependent) have received NAET for. If I (my dependent) come in contact with the substance(s) for which I (my dependent) am desensitized, I realize that the NAET may not work and I (my dependent) may have a sensitivity reaction.

I understand that I (my dependent) must return after my 25-hour-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 be required to repeat the procedure (more office visits at my cost) until I (my dependent) clear them satisfactorily.

After the successful completion of my NAET® program I give permission to my doctor/practitioner to use my (my ward's) case study in educating other similar patients or accumulating data for research purposes 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 problem, etc.) to use for research or patient education purposes 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)

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RELEASE FORM

I give my consent to Dr. Allen or his/her associates to use my (my ward's) diagnosis and treatment data and my (my ward's) photographs if applicable in a flier, journals, research or other publishing purposes without revealing my real name and age.
Patient's Signature:________________________________Print______________________Date:_____________
Name of the Minor____
Relationship to the ward (mother/father/guardian/husband/wife)
Parent's /guardian's Signature ____Date _________________

Consent To treatment

I______________________________hereby consent, authorize and request Allen Chiropractic Care 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___________________________ Signature__________________________ Date ____________

To Be Filled By Doctor/ Physical Examination

Temp: _________Pulse:____________ Resp:___________ Blood Pressure.: Sitting____________
Lying___________ General appearance: ____
____
____
X-rays: What part?____
Date___________Findings____
Lab work done _____________________Please bring a copy of your results___________________________
NST Evaluation Date: _______________________ Findings _______________________________________
____
____
Special Lab work performed ____
Diagnosis ____
____
____
____
Treatment plan____
____
____
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____
____
____
____
Referral Any ____________________________________ To Whom ____________________________________
Date of Discharge. ________________Final diagnosis at Discharge __________________________________
____
____
Name of Doctor ___________________________ Signature at Discharge______________________________