NES Client Information

Name _____Today's Date _____
Address _____email _____
City _____ State _____ Zip _____
Home phone _____Work phone_____ Cell phone _____
Age _____ Birth Date _____ Time _____ City & state_____
Occupation: Job title _____
Name of company _____
In case of emergency, notify _____ Phone _____
Referral source _____

Marital status: (Circle one) Single Married Divorced Separated Widowed

Spouse or partner _____Marriage or beginning date _____
Age _____ Birth Date _____ Time _____ City & state_____
Occupation: Job title _____
Name of company _____

Children:

Name _____ Age ____ Grade ____ Birth Date _____
Name _____ Age ____ Grade ____ Birth Date _____
Name _____ Age ____ Grade ____ Birth Date _____
Name _____ Age ____ Grade ____ Birth Date _____

Medical problems _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Current medication _____
_____
_____

REVIEW OF SYSTEMS

Please **circle** if you are currently experiencing any of the following
or write a **P** if you experienced it in the past.

General symptoms
Headache
Head injury
Fever
Chills
Sweats
Dizziness
Fainting
Loss of sleep
Fatigue
Nervousness
Loss of weight
Numbness or pain in arms/legs/hands
Allergy
Convulsions

Skin
Hives or allergy
Acne or skin eruptions
Itching
Bruises easily
Dryness
Boils
Varicose veins
Sensitive skin
Change in mole

Kidneys & Reproduction
Inability to control urine
Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection
Kidney stones
Prostate trouble
Sores on genitals

Eyes,Ears,Nose,Throat
Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Tonsillitis
Sore throat
Hoarseness
Enlarged glands
Glaucoma
Failing vision
Cataracts
Eye pain
Ear discharge
Deafness
Ear ache
Nasal drainage
Nose bleeds
Nasal obstruction
Sinus infection
Hay fever
Mercury tooth fillings

Muscle & Joint
Stiff neck
Back pain
Muscle weakness
Swollen joints
Painful tailbone
Foot trouble
Pain in shoulders
Hernia
Spinal curvature
Faulty posture
Arthritis
Fracture/dislocation

Cardiovascular
Low blood pressure
High blood pressure
Previous heart stroke
Hardening of the arteries
Swelling of the ankles
Poor circulation
Paralytic stroke
Irregular heart beat
Shortness of breath
Chest pain

Gastrointestinal
Excessive thirst
Excessive hunger
Belching
Gas (flatulence)
Nausea
Vomiting
Vomiting of blood
Abdominal cramps
Constipation
Diarrhea
Colon trouble
Hemorrhoids (piles)
Intestinal worms
Liver problems
Gallbladder problems
Jaundice
Colitis

Respiratory
Asthma
Chronic cough
Spitting up phlegm
Spitting up blood
Difficult breathing

What are your treatment goals and expectations? _____
_____
_____

Is there anything else that you feel has not been covered? _____
_____
_____
_____
_____
_____
_____

Thank you very much for taking the time to complete this form.