Client File No. _____
1128 Holistic Healing, Cheryl Boehle
Telephone No. 414-416-8996
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New Client History Form (Please print legibly)

Name_____ Telephone (_____)_____

Address_____ City_____ State _____ Zip_____

DOB_____/_____/_____ Age_____ Sex: M____ F____ Height _____ Weight_____

Employer_____ Occupation_____ Work Phone(_____)_____

Address_____ City_____ State _____ Zip_____

Driver's License_____ State_____ Exp. Date_____/_____/_____

Marital Status: Single Married Divorced Widowed No. of Children ____ Girls___ Boys___

Name of Spouse (if applicable)_____ Telephone (_____)_____

Spouse Employer_____ Occupation_____ Telephone (_____)_____

Address_____ City_____ State _____ Zip_____

Person financially responsible (if client is a minor)_____

Emergency Contact_____ Relationship_____Telephone (_____)_____

Referred By:_____

Payment is due at the time of treatment/service. Cash pay only. No insurance accepted.

Consent to treatment

I, _____ hereby consent, authorize, and request Cheryl Boehle, 1128 Holistic Healing, to administer the treatment deemed advisable and necessary to my/my ward's condition in accordance with her expertise. I agree to hold Cheryl Boehle and 1128 Holistic Healing free and harmless from any claims, suits for damages or complications which may result from such treatment.

Client Signature_____ Dated_____/_____/_____

Witness Signature_____ Dated_____/_____/_____

Initial Visit $_____ Follow-up visits $_____

Client & Family History:

Date_____/_____/_____ Current Age of Client_____
Birthplace of Client _____
Place lived until 5 years old _____
Parents living or age at death: Father(age)_____ Mother(age)_____
Paternal Grandparents living or age at death: Father(age)_____ Mother(age)_____
Maternal Grandparents living or age at death: Father(age)_____ Mother(age)_____
Paternal Great Grandparents living or age at death: Father(age)_____ Mother(age)_____
Maternal Great Grandparents living or age at death: Father(age)_____ Mother(age)_____
Brothers_____ Sisters_____
First Cousins_____
Family History of (please specify who in the family has or has had it)
Diabetes _____
Alcoholism _____
Asthma _____
Arthritis (also identify type)_____
Cancer (also identify type) _____
Mental disease (also identify type) _____
Migraines _____
Heart disease (also identify type) _____
Lung disease (also identify type) _____
Kidney disease (also identify type) _____
Allergies (also identify type) _____
Any specific infections (also identify type) _____
Any other rare disease(s)(also identify type) _____
Did your mother have gestational diabetes: Yes_____ No_____
Heavy metal toxicity: Yes___ No___ Mercury toxicity: Yes___ No___ Severe Yeast Infection: Yes___ No___
Gluten sensitivity: Yes_____ No_____ Do you have a relative with a similar problem? Yes_____ No_____
If yes, what is the relationship to the client? _____
Was the mother on any prescriptions or other drugs during pregnancy? Yes_____ No_____
During delivery? Yes_____ No_____ After Delivery? Yes_____ No_____ Specify_____
During pregnancy did the mother use: Tobacco Yes_____ No_____ Alcohol Yes_____ No_____
Other Recreational Drugs: Yes_____ No_____ Specify_____
Did you experience any head injury during infancy or childhood? Fall Yes___ No___ Accident Yes___ No___
Have you experienced "sudden fright" for any reason? Yes_____ No_____ Explain in detail _____
_____

Personal History

Childhood diseases (check all that apply): Measles___ Mumps___ Chickenpox___ Strep Throat___ Mono ___
Any unusual childhood diseases? _____
Any severe reaction to medications? _____
List unusual events _____
Describe _____
List any surgeries _____
List prescriptions that you take _____
List vitamins/supplements that you take _____
Do you use recreational drugs? Yes_____ No_____ List_____

Symptom Survey Form			
File No:	Date:	Sex: M F	DOB/AGE:
Name:		Diagnosis:	

If you are experiencing, or have experienced, any or all the following, please indicate by checking (1) **mild** symptoms, (2) **moderate** symptoms, or (3) **severe** symptoms. Leave any symptom not present blank.

	1	2	3
Abnormal appetite poor/excess			
Abdominal bloating			
Absent mindedness			
Abnormal hair growth			
Acid foods upset			
Acne			
Addiction to smoke			
Addiction to sugar			
Addiction to drug			
Addiction to drugs			
Addiction to spices			
Anemia			
Anger			
Arthritis			
Asthma bronchial			
Asthma cardiac			
Athlete's Foot			
Bad Breath			
Backache (upper area)			
Backache (middle area)			
Backache (lower area)			
Blurred vision			
Bowel disorders			
Brain fog			
Breast pain/swelling			
Breast lumps			
Bronchitis			
Brown spots			
Bruises easily			
Burning/itching anus			
Burning feet			
Coated tongue			
Cold sweats often			
Colds/flu's frequent			
Colitis			
Compulsive behavior			
Constipation			
Cold extremities			
Cough			
Cradle cap			
Crave spices			

	1	2	3
Crave salt			
Crave sweets			
Crave sour/bitters			
Crave onions/beans			
Chronic fatigue			
Cuts heal slowly			
Dandruff			
Decreased sex drive			
Depression			
Diabetes			
Diarrhea			
Difficulty walking			
Difficulty swallowing			
Digestion rapid			
Diverticulitis			
Dream disturbed sleep			
Dry nose			
Dry eyes			
Dry mouth			
Dyslexia			
Earaches			
Ear infection			
Eating disorder			
Eczema			
Edema			
Emotional imbalances			
Elbow pain			
Excess thirst			
Eyelids puffy			
Eyes watery			
Eyes itch			
Fainting spells			
Fatigue			
Feels cold often			
Feels insecure			
Fever			
Fibromyalgia or body ache			
Forgetfulness			
Frequent rashes			
Gags easily			
Gall stones			

If you are experiencing, or have experienced, any or all the following, please indicate by checking (1) **mild** symptoms, (2) **moderate** symptoms, or (3) **severe** symptoms. Leave any symptom not present blank.

	1	2	3
Gastric distress			
General itching			
Greasy foods upset			
Hair loss			
Hay fever			
Headaches/sinus			
Headaches-morning			
Headaches-afternoon			
Headaches-evening			
Headaches-migraine			
Hearing decreased			
Heartburn			
Heart irregularities			
Hemorrhoids			
Herpes			
High altitude problems			
High blood pressure			
Hip pains			
Hives			
Hoarseness			
Humidity discomfort			
Hungry between meals			
Hyperactivity			
Ileocecal valve			
Increased sex drive			
Indigestion			
Infertility			
Insomnia			
Internal trembling			
Irritable/restless/keyed-up/fail to calm			
Knee pains			
Labored breathing			
Low blood pressure			
Lump in 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			

	1	2	3
Mucus production			
Muscle cramps/spasms			
Nasal polyp			
Nausea or vomiting			
Neck pains			
Nervous stomach			
Neuralgia			
Night sweats			
Nosebleed			
Numbness			
Obsessive behavior			
Ovaria cyst			
Pain between shoulders			
Pain on the heels			
Pain-unexplained			
Pain-shoulder			
Perspiration excess			
Phobias			
PMS (premenstrual syndrome)			
Poor memory			
Postnasal drip			
Premature graying			
Prolapse uterus or bladder			
Prone to infections			
Prostate issues			
Psoriasis			
Red or pink eyes			
Restless leg syndrome			
Ring worm			
Ringing in ears			
Seizures			
Sensitive to cold/heat			
Shortness of breath			
Shoulder pain			
Sighs frequently			
Sinusitis			
Skin issues			
Sleepy during day			
Slow pulse <65			
Slow starter			
Smell decreased			
Sneezing attacks			
Sore throat			
Sore canker			
Sour stomach			

If you are experiencing, or have experienced, any or all the following, please indicate by checking (1) **mild** symptoms, (2) **moderate** symptoms, or (3) **severe** symptoms. Leave any symptom not present blank.

	1	2	3
Startles easily			
Strong light irritation			
Swollen ankles/feet			
Thinning/Thickening of skin			
Throat construction/closing			
Tightness in the chest			
Tingling sensation all over the body			
Tires easily			
Tourette's Syndrome			
Urinary tract disorder			
Urination difficulty			

	1	2	3
Urine volume increase/decrease			
Uterine polyp			
Vaginal discharge			
Varicose veins			
Warts			
Weak nails			
Weight gain			
Weight loss			
White spots over the body			
Worrier			
Yeast Infection			

Other conditions you are experiencing, or have experienced, please indicate the condition, and identify as (1) **mild** symptoms, (2) **moderate** symptoms, or (3) **severe** symptoms.

	1	2	3

	1	2	3

Is there any other issue that you would like your practitioner to be aware of prior to the start of any treatment?

Client Consent Affirmation

I, _____ (print name) certify that Cheryl Boehle, 1128 Holistic Healing, does not claim to cure any illness or disease with Nambudripad's Allergy Elimination Techniques (NAET). 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 client'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 the above-mentioned disciplines) so that the client may not experience hypersensitive symptoms when they have future contact with these desensitized substances.

I understand that I, or my dependent, am 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 of NAET desensitization procedures, if I, or my dependent, get a life-threatening reaction from the allergen, I, or my dependent, was desensitized through NAET earlier or the reaction happened from some other source, I need to seek immediate help from a physician qualified in emergency care. If I, or my dependent, is suffering from a severe allergic reaction 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 myself, or my dependent, symptoms under control while I, or my dependent is receiving NAET treatment.

I understand that for 25 hours after the NAET treatment (avoidance period), I, or my dependent must avoid eating, touching, breathing, and/or coming within five (5) feet or more of the substance(s) that treatment was performed for. It is understood that if I, or my dependent, fail on the above, that the NAET treatment that was performed may not work and that I, or my dependent, may have a sensitivity reaction.

I understand that I, or my dependent, have been advised to return within a week to determine whether the treatment has cleared the allergen.

After the successful completion of the NAET program, I give permission to my practitioner to use my, or my dependent'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, or my dependents, diseased body part (e.g. in case of skin problems, etc.) to use in research or client education 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 agree to the terms and procedures.

Client Signature_____ Date_____/_____/_____

Name of Minor/Dependent_____ Relationship_____

Signature of Witness_____ Date_____/_____/_____

Print Witness Name_____