Boise Natural Health Clinic

4219 W. Emerald Street, Boise, ID 83706 | office 208-338-0405 | fax 208-422-9957 | www.boisenaturalhealth.com

FLU TREATMENT INTAKE FORM

Today's Date_____

PERSONAL INFORMATION

Full Name_____I like to be called _____
(First Middle Initial Last)

Age_____ Date of Birth_____ Gender Identity_____

Address_____

City_____ State_____ Zip_____

Phone (best)_____Email address _____

Occupation_____

Children's names and ages: (if being treated)_____

_____

Emergency Contact (name & relation)_____

Contact's Phone (home)_____ (work)_____ (cell)_____

Who referred you here today? _____

Please CIRCLE which practitioner(s) see you:

Dr. Dickerson, Dr. Pierce, Dr. Haynes, Emily Richmond Yuen

Would you like to receive our FREE Monthly E-Newsletter with health news & events? Y N

MEDICAL HISTORY

Have you had an allergic reaction to any vaccinations or medications?_____

_____

If so, what?_____

Have you had a history of anaphylaxis to anything? Y N

If so, what?_____

Do you have scoliosis of the spine? Y N

Are you currently pregnant? Y N

Are you allergic or sensitive to any foods? Please list:_____

_____

Is there anything else you wish to add?_____

_____

_____

Waiver:
We at Boise Natural Health Clinic can't guarantee that you will not get the flu this year. But we are providing you with tools to help yourself if you do become sick. You may experience fatigue, headaches, gas, mild aches during the 25 to 48 hours after the NAET Flu treatment. Please do your gate points every 2 waking hours for the next 25 hours (see handout for locations of gate points). Please avoid intentional exposure to someone with influenza for the next 25 hours.

You are also being treated for vaccine ingredients today. If you have ever had a reaction to vaccinations or their ingredients today's treatment may cause detoxification symptoms that may include brain fog or symptoms similar to your reaction. If it lasts beyond 48 hours you may come back in and be treated again to help the symptoms stabilize at no charge.

I know that I will get best results if I receive a booster treatment that is included in the fee within 1 to 2 weeks of my first visit.

I understand that if I want to make sure that I received 100% of the benefit from the treatments that a practitioner would need to muscle test me within a week after the booster treatment. This is not necessary but if it is important to me I know that I can call and schedule a brief follow up and possible retreatment if needed. If I desire to do this the cost is $15.

I understand that there is no guarantee and that I may experience mild flu like symptoms. I willing agree to the treatments. Y N

I have scoliosis that is more than mild or I elected to be treated through a surrogate (not have the treatment done directly on my back). Y N
I am currently pregnant and wish to be treated through a surrogate. Y N

If I need a surrogate I will let the office know in advance by calling 208-338-0405 or I will bring an adult with me to by my surrogate.

****** By participating in the flu treatment day, I AGREE TO FILL OUT A BRIEF SURVEY AT THE END OF FLU SEASON to determine how helpful this was for me and my family.

Signed _____ Dated _____

I give permission for my child(ren) _____to

receive NAET flu treatments.

Thank you for taking the time to complete this form.