7269 Highway 26 Stayner (inside Sutton Realty building, beside the TD Bank) 705-321-3077
nancy@naet.ca

Name:_____Date:_____
Parent/Guardian Name:_____D.O.B._____
Address:_____Family Doc._____
City_____
Province_____
Postal Code_____
Email -_____
Telephone (H)_____
(cell)_____text messaging Y N

How did you hear about NAET Healthy By choice?_____
Has your child ever had allergy testing done? Yes_____No_____
Does your child have any known allergies? Yes_____No_____
If yes, list the allergies and reactions_____
_____
_____
_____

Has your child ever had an anaphylactic reaction to anything?
(this is when the throat swells and it is difficult to breathe) Yes_____No_____
If yes, do you carry an Epipen Yes_____No_____

Check any medical conditions that apply to your child.
_____Allergies/Sensitivities
_____Asthma: Puffers? Yes____No____
_____Eczema/Dermatitis
_____Candidiasis/Yeast Infections
_____Diabetes: Insulin? Yes____No____
_____Anorexia
_____Autism

_____ADD (Attention Deficit Disorder)
_____ADHD (Attention Deficit & Hyperactivity Disorder)
_____Dyslexia
_____Headaches/Migraines
_____Pain: Where? _____
_____Other_____
_____

Check any surgeries that apply to your child:
_____Tonsils
_____Sinus

_____Other_____
_____

Check any of the following symptoms that apply to your child

Irritability
Spaced out feeling, brain fog
Depression for no specific reason
Inability to concentrate
Jekyll/Hyde mood swings
Tearfulness
Phobic/compulsive tendencies
Overactive/hyperactivity
Chronic anger for no reason
Panic attacks
Aggressiveness, abusive, hostile
Stomach upset
Chronic bad breathe
Coated tongue
Candida
Colic, excessive spitting up in infancy
Diaper rash in infancy
Bowel problems
Constipation
Diarrhea
Irritable bowel
Persistent cough
Frequent bedwetting
Mouth breathing
Fatigue, laziness
Runny nose
Nasal congestion
Recurrent ear/throat/chest infections
Anxiety
Insecurity
Hives/dermatitis, itching
Itchy, watery or dry eyes
Acne
Cheeks flushing, red ears
Crease from rubbing nose upwards
Wrinkles, dark circles under eyes.
overly thin
Growing pains
Increasing sensitivity to foods/chemical
Headaches/migraines
Nose bleeds
Clumsiness
Night wakefulness, insomnia
Car sickness
Picky or binge eater
Pale face
Leg wiggling, restlessness
Other_____.

Did your child's symptoms appear after any of the following?
_____Childhood illness (ie. Whooping cough, measles or immunizations)

_____Other illness (ie. Influenza, pneumonia or surgery)
_____Adolescence
_____Any major physical or mental trauma (ie. Automobile accident)

Has your child been on antibiotics more than twice a year? Yes_____, No_____