Wise Chiropractic NAET Consent Form

I, ______________________________, certify that Dr. Jonathan Wise does not claim to cure any illness or disease with NAET (Nambudripad's Allergy Elimination Technique).

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, Kinesiological, and Acupuncture) to diagnose the patient's condition. The premise behind NAET is the balance the energy of the individual patient to a substance(s) using NAET (this procedure uses information from allopathic, chiropractic, acupuncture/acupressure, nutritional and applied kinesiology) so that the patient may not experience hypersensitive symptoms when they have future contact with them.

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 or after if I (my dependent) get a life-threatening reaction from the allergen I (my dependent) was given NAET EBP earlier or from some other sources, I need to seek emergency help immediately from a physician qualified in emergency care or by calling 911 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 medications (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) amgoing through NAET energy balancing procedures (EBP). This way NAET EBP program can be satisfactoryily completed on the basic allergens without interruption and once I (my dependent) complete NAET EBP for my (my dependent's) condition, I (my dependent)may experience reduction of my allergic symptoms and improved quality of life.

I understand that for 25 hours after the NAET EBP, I (my dependent) am to avoid eating, touching, breathing and coming within 5 feet or more as it was instructed by my practitioner of the substance(s) for which I (my dependent) am being energy balanced, I realize that EBP may not work and I (my dependent) may have a sensitivity reaction.

I understand that I (my dependent) must return after my 25 hours 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) if unknow 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 require to repeat the procedure (more office visits at my cost) until I (my dependent) clear them satisfactorily.

After the successful completion of my NAET EBP program I give permission to Dr. Jonathan Wise/Wise Chiropractic to use my (My Ward'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 (my ward's) diseased body part (e.g. in case of skin problems, etc...) to use in research or patient education purpose 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 Name	Patients Signature	Date
______________________	______________________	
Name of Minor/Dependent/Ward	Relationship to the Ward	

Allergy Symptom Rating Scale

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.

File No: ___________ **Date** _____________ SEX: M [ ] F [ ]. AGE/

Name: ______________________________ DOB _______________

Symptoms	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 alcohol			
Addiction to drug			
Allergic to drugs			
Addiction to spices			
Anemia			
Anger			
Appetite -excess			
Arthritis			
Asthma bronchial			
Asthma cardiac			
Athelete's foot			
Bad breath			
Backache - (upper area)			
Backache (middle area)			
Backache (Lower area)			
Blurred vision			
Bowel disorders			
Brain fog			
Breast pain or 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			
Crave salt			
Crave sweets			
Crave sour / bitters			
Crave onions/ beans			
Chronic Fatigue			

Symptoms	1	2	3
Cuts heal slowly			
Dandruff			
Decreased sex drive			
Depression			
Diabetes			
Diarrhea			
difficulty in walking			
Difficulty in swallowing			
Digestion rapid			
Diverticulitis			
Dream disturbed sleep			
Dry nose			
Dry eyes			
Dry mouth			
Dyslexia			
Ear aches			
Ear infection			
Eating disorder			
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			
Forgetfillness			
Frequent rashes			
Gags easily			
Gall stones			
Gastric distress			
General itching			
Greasy foods upset			
Hairloss			
Hayfever			
Headaches/sinus			
Headache/morning			
Headache/afternoon			
Headaches - migraine			
Hearing decreased			
Heartburn			

Allergy Symptom Rating Scale

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.

Name:________________________ SEX: M [ ] F [ ]. AGE/DOB________

Symptoms	1	2	3
Heart irregularities			
Hemorrhoides			
Herpes			
High altitude causes problems			
High blood pressure			
Hip pains			
Hives			
Hoarseness			
Humidity-discomfort			
Hungry between meals			
Hyperactivity			
Hysterectemy			
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			
Neck pains			
Nervous stomach			
Neuralgia			
Night sweats			
Nose bleed			
Numbness			
Obsessive behavior			
Overia cyst			
Pain between shoulders			
Pain on the heels			
Pain-unexplained			
Pain - shoulder			

Symptoms	1	2	3
Perspiration excess			
Phobias			
PMS (premenstual symptom)			
Poor memory			
Post nasal drip			
Premature grayting			
Prolapse uterus or bladder			
Prone to infections			
Prostate trouble			
Psoriasis			
Red or Pink eyes			
Restless leg syndrome			
Ring worm			
Ringing in the ears			
Seizures			
Sensitive to cold /heat			
Shortness of breath			
Shoulder pains			
Sighs frequently			
Sinusitis			
Skin problems			
Sleepy during the day			
Slow pulse < 65			
Slow starter			
Smell decreased			
Sneezing attacks			
Sore throat			
Sore canker			
Sour stomach			
Startles easily			
Strong light irritates			
Swollen ankles and feet			
Thinning / thickening of the skin			
Throat constriction/throat closing			
Tightness in the chest			
Tingling sensation all over the body			
Tires too easily			
Tourette's Syndrome			
Urinary tract disorder			
Urination difficult			
Urine amount increased /decreased			
Uterine polyp			
Vaginal discharge			
Varicose veins			
Warts			
Weak nails			
Weight gain			
Weight loss			
White spots over the body			
Worrier			
Yeast infection			
Other			