

**Inner Light Wellness New Patient Form**  
**Margaret Celli, L.Ac., NCCAOM**

Name \_\_\_\_\_ Address \_\_\_\_\_

Phone  
(H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ E-Mail \_\_\_\_\_

Emergency  
Contact \_\_\_\_\_ Phone \_\_\_\_\_

Medications/Vitamins \_\_\_\_\_

Physician \_\_\_\_\_ Referred by \_\_\_\_\_

Primary reason for visit \_\_\_\_\_

When did symptoms first appear? \_\_\_\_\_ Are they worsening? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Other health concerns \_\_\_\_\_

Previous injuries (describe and date) \_\_\_\_\_

Surgery/Hospitalizations (describe and date) \_\_\_\_\_

Have you ever had acupuncture/herbs? \_\_\_\_\_ Are you receiving other therapies? \_\_\_\_\_

Describe \_\_\_\_\_

**MEDICAL HISTORY:**

**Your history:**

\_\_\_\_ Heart disease                      \_\_\_\_ Blood clots                      \_\_\_\_ Spinal Problems

\_\_\_\_ Bleeding disorder                  \_\_\_\_ Diabetes                          \_\_\_\_ Osteoporosis

\_\_\_\_ Low Blood Pressure                \_\_\_\_ High Blood Pressure            \_\_\_\_ Stroke

\_\_\_\_ Hepatitis                            \_\_\_\_ Alcoholism/Drug addiction      \_\_\_\_ Cancer

\_\_\_\_ HIV/AIDS                            \_\_\_\_ Allergies                          \_\_\_\_ Asthma

\_\_\_\_ Appendicitis                        \_\_\_\_ Depression                        \_\_\_\_ Pneumonia

\_\_\_\_ Serious Fever                        \_\_\_\_ Seizures                            \_\_\_\_ Chicken Pox

\_\_\_\_ Kidney Disease                      \_\_\_\_ Thyroid Disorder                \_\_\_\_ Measles

Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Family History:**

- Heart disease                       Blood clots                       Cancer
- Diabetes                                 High Blood Pressure             Osteoporosis
- Stroke                                     Alcoholism                         Allergies

Other: \_\_\_\_\_

Stressors affecting your life \_\_\_\_\_

**WOMEN:**

(If you are post-menopausal, please answer the following based on menstrual history.)

Describe your typical menstruation \_\_\_\_\_

- Age menses began                       Clots                                 Color of menses
- Length of cycle                         Cramping                         Length of flow
- Vaginal discharge                       Vaginal odor                       Vaginal Dryness
- #Pregnancies                             #Births                             #Miscarriages
- Fibroids/Cysts                         Yeast infections                       #Abortions
- Bladder infections                       Genital herpes                       Genital warts
- Painful intercourse                       Low libido                         Sexual dysfunction
- Oral contraceptives                       HRT                                 Breast lumps/tenderness
- Recent change in menses (describe) \_\_\_\_\_

Any other menstrual issues? \_\_\_\_\_

**MEN:**

- Difficulty starting urination                       Stopping and starting urination
- Urinary dribbling                         Urgent urination
- Premature ejaculation                       Difficult to attain/maintain erection
- Genital pain                               Low libido
- Genital rash                               Genital herpes
- Enlarged prostate                         Genital warts

**DIET:**

- Low Appetite                             Heavy Appetite                       Coffee/Tea
- Meat                                       Vegetarian                         Vegan
- Thirsty                                     Prefer Hot Beverages             Prefer Cold Beverages
- Crave Sweets                             Crave Salt

**Average Daily Menu:**

Breakfast	Snack	Lunch	Snack	Dinner	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**For the following symptoms, please indicate your experience as follows:**

**1=occasionally**

**2=frequently**

- \_\_\_ Feeling of Heat in Chest
- \_\_\_ Shortness of Breath
- \_\_\_ Chest Pain
- \_\_\_ Heart Palpitation
- \_\_\_ Tight Chest
- \_\_\_ Irregular Heartbeat
- \_\_\_ Heart Attack
- \_\_\_ Difficult to Fall Asleep
- \_\_\_ Difficult to Stay Asleep
- \_\_\_ Dream Disturbed Sleep
- \_\_\_ Anxiety
- \_\_\_ Agitation
- \_\_\_ Restlessness
- \_\_\_ Easily Startled
- \_\_\_ Poor Memory
- \_\_\_ Speech Difficulty
- \_\_\_ Ulcers Mouth/Tongue
- \_\_\_ Cold/Swollen Hands

- \_\_\_ Asthma
- \_\_\_ Allergy
- \_\_\_ Sinus Problem
- \_\_\_ Nosebleeds
- \_\_\_ Sore Throat
- \_\_\_ Dry Throat/Mouth
- \_\_\_ Loss of Voice
- \_\_\_ Dry Cough
- \_\_\_ Wet Cough
- \_\_\_ Coughing Blood
- \_\_\_ Bronchitis
- \_\_\_ Pneumonia
- \_\_\_ Easily Sweat
- \_\_\_ Absence of Sweat
- \_\_\_ Dry Skin
- \_\_\_ Skin Rash
- \_\_\_ Itching

- \_\_\_ Fatty Tumors
- \_\_\_ Goiter
- \_\_\_ Spider Veins
- \_\_\_ Lumps

- \_\_\_ Frequent Urination
- \_\_\_ Painful Urination
- \_\_\_ Difficult to Pass Urine
- \_\_\_ Inability to Hold Urine
- \_\_\_ Dark/Pale Urine
- \_\_\_ Blood in Urine
- \_\_\_ Nighttime Urination
- \_\_\_ Urgent Urination
- \_\_\_ Lack of Sex Drive
- \_\_\_ Premature Gray
- \_\_\_ Low Back Pain
- \_\_\_ Knee Pain
- \_\_\_ Kidney Stones
- \_\_\_ Hearing Loss
- \_\_\_ Night Sweating
- \_\_\_ Ear Ringing (Low)
- \_\_\_ Swollen Legs/Feet
- \_\_\_ Cold Feet

- \_\_\_ Fatigue
- \_\_\_ Indigestion
- \_\_\_ Heartburn
- \_\_\_ Bleeding Gums
- \_\_\_ Abdominal Pain
- \_\_\_ Constipation
- \_\_\_ Diarrhea/Loose Stool
- \_\_\_ Mucus in Stool
- \_\_\_ Blood in Stools
- \_\_\_ Dizzy if Stand Too Fast
- \_\_\_ Nausea
- \_\_\_ Belching
- \_\_\_ Bloating
- \_\_\_ Acid Regurgitation
- \_\_\_ Thirst Excess/Little
- \_\_\_ Easy Bruising
- \_\_\_ Feel Heavy
- \_\_\_ Varicose Veins
- \_\_\_ Hemorrhoids
- \_\_\_ Bad Breath
- \_\_\_ Weak Muscles

- \_\_\_ Stress
- \_\_\_ Headaches
- \_\_\_ Sighing
- \_\_\_ Depression
- \_\_\_ Lump in Throat
- \_\_\_ Anger/Irritation
- \_\_\_ Light Sensitivity
- \_\_\_ Dry Eyes
- \_\_\_ Red/Itchy Eyes
- \_\_\_ Poor Night Vision
- \_\_\_ Spots/Floaters
- \_\_\_ Ridged Nails
- \_\_\_ Numb/Tingling
- \_\_\_ Rib Pain
- \_\_\_ Spasms/Tics
- \_\_\_ Ear Ringing(Hi)
- \_\_\_ Dizziness
- \_\_\_ TMJ-Grinding
- \_\_\_ Breast Pain
- \_\_\_ Glasses

Bowel Movements:  
 Frequency \_\_\_\_\_  
 Color \_\_\_\_\_  
 Texture \_\_\_\_\_  
 (loose or formed)

Pain?  
 Location \_\_\_\_\_  
 \_\_\_\_\_

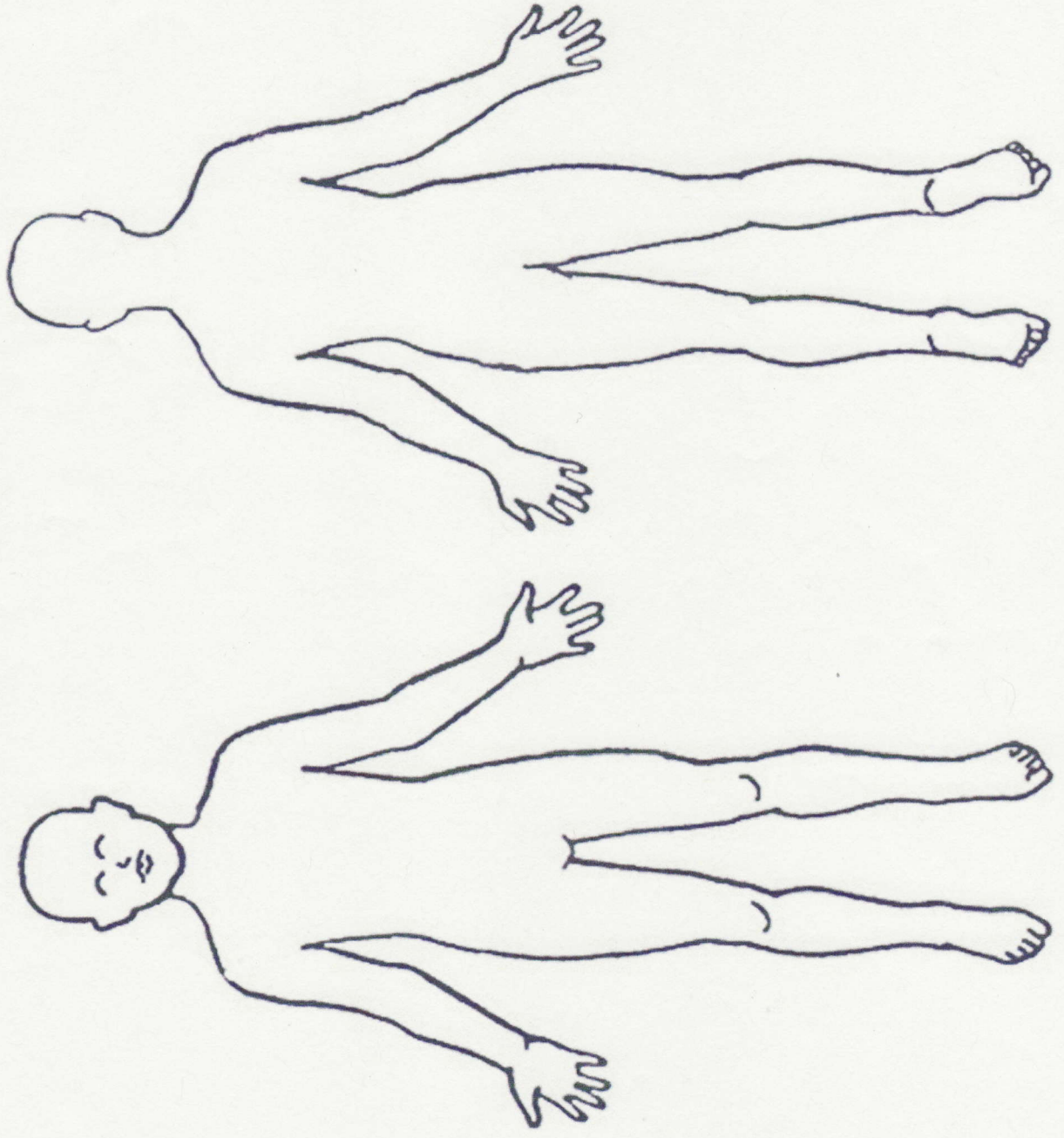
Describe \_\_\_\_\_  
 \_\_\_\_\_

Does it radiate? \_\_\_\_\_  
 Rate the severity 1-10  
 \_\_\_\_\_

Does it interfere with  
 daily activity? \_\_\_\_\_

Headache?  
 Describe \_\_\_\_\_  
 \_\_\_\_\_

Using the colored pen, please shade in areas of pain or tension.  
Please include areas of radiating pain.



## NAET Health Questionnaire

Have you had NAET before?

Have you had other type of allergy treatment?

If yes, what type of treatment did you receive?

To what foods do you think you are allergic?

To what environmental items do you think you are allergic?

Describe your most severe allergic reaction.

Do you have immediate family members who are allergic?

When did your allergies first begin?

Was there some stressful or traumatic event that occurred about the time your allergies began? (accident, divorce, severe illness, etc)

List any prescription medications:

List any dietary supplements:

Do you have seasonal allergies?

Are your allergies more severe at different times of the day?

When are they worse?

Describe your physical allergic symptoms.

Describe the way you feel emotionally when you have a flare up of allergic symptoms.

Do you feel better or worse at work?

Do you feel better when you travel?

How is your energy level?

Do you have any problems with concentration, comprehension, and memory?

Are there any further comments that you would like to add?

If you have had NAET treatments before, please answer the following seven questions:

1. Did you pass your treatments easily?
2. Did you have to repeat many treatments?
3. Are you no longer allergic to the items for which you were treated?
4. Did you require many combination treatments?
5. Did you require many emotional treatments?
6. Were you uncomfortable during the 24 hour post treatment period?
7. List as many items as you can for which you were treated.