AUTHENTIC LIVING CENTER

NET Questionnaire

(Please complete both sides)

Name:_____Date:_____

Primary Complaint: _____

How does it affect your life? _____

_____

Is this the first time you have experienced this problem? __ yes __ no

If no, please describe any treatment you may have previously received for this problem: _____

_____

_____

Are you still receiving treatment? __ yes __ no

Are you under a Doctor's care for any other conditions? __ yes __ no

If yes, please describe (include Doctor's name, condition(s) and type(s) of treatment:_____

_____

_____

_____

Please list all prescription medications you are currently taking:_____

_____

_____

_____

Please list all vitamins & supplements you are currently taking:_____

_____

_____

_____

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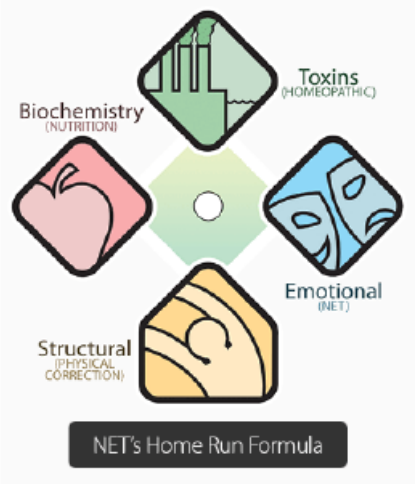
Family Dynamics:



Parents: Living?_____

Deceased?_____

Divorced? _____

Remarried? _____

Siblings: How Many?_____

Where are you in the order? _____

Deceased?_____

Rate yourself:

How well do you understand Holistic methods? (pleaase circle one)

0 1 2 3 4 5 6 7 8 9 10

No understanding Understand very well

How open-minded do you feel you are? (please circle one)

0 1 2 3 4 5 6 7 8 9 10

Closed Highly Open-Minded

What type of outcome are you hoping to gain from this treatment? _____

_____

_____

_____