Dr. Theresa M. Pigott

Holistic Chiropractor
Shamanic Practitioner
End-of-Life Doula

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? ______________________________

____

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☐ I grant permission to be contacted by Authentic Living Center by email.

☐ I grant permission to be contacted by Authentic Living Center by text.

Signature: ____ Date________________