Name:_______________________________Date:_______________

NET Questionnaire

(Please complete both sides)

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 condition(s)? ☐ Yes ☐ No

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

____
____

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____

____
____

Please list all prescription medications you are currently taking:

Please list all vitamins & supplements you are currently taking:

____
____

____
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____
____

Family Dynamics:

Biochemistry (NUTRITION)
Toxins (HOMEOPATHIC)
Emotional (NET)
Structural (PHYSICAL CORRECTION)
NET's Home Run Formula

Parents: Living? _______________________________

Deceased? ____________________________

Divorced? _____________________________

Remarried? ____________________________

Siblings: How many? _________________________

Where are you in the order? _____________

Deceased?

____

Rate yourself:

How well do you understand Holistic methods? (please 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?

____

____

____