Client Name: ______________________

Today's Date: ______________________

Address: ______________________

Date of Birth: ______________________

City, Prov, Postal Code: ______________________

Phone #: ______________________

Gender: MALE ___ FEMALE ___

Email: ______________________

Primary Care Physician: ______________________

Referring Physician: ______________________

Although your history and symptoms are very important in our analysis of your condition, it is also important to me that you understand.

- I do not treat symptoms or disease.
- An allergy is not a disease, rather a condition.
- A symptom is an attempt by your body to tell you something.
- I will attempt to find the underlining cause.
- I do not use drugs in this program.
- There is no single "healthy" diet that will work for everyone.
- Just because food is considered "healthy", does not mean it is "healthy" for you.
- Your diet consists of everything you eat, drink, rub on your skin, or inhale.
- These procedures are safe and painless.

Briefly describe the reason for your visit and what you hope to accomplish:

____

____

____

AGE WHEN SYMPTOMS WERE FIRST OBSERVED

☐ Infant (Age 0-2) ☐ Child Age (Age 3-5) ☐ Child (Age 6-12)

☐ Adolescent (Age13-18) ☐ Adult (age 19-25 ☐ Adult (Age 26-40)

☐ Adult (Age 41 and over)

PREVIOUS ALLERGY EVALUATION

Have you ever seen an allergist? ☐ Yes ☐ No

Have you had allergy skin testing? ☐ Yes ☐ No

Did you have any positive reaction? ☐ Yes ☐ No

If yes, please list positive allergens (including any medications)

____

Have you ever received allergy injections? ☐ Yes ☐ No

WORK ENVIRONMENT

What is your occupation? ____

Are you exposed to chemicals or strong odors at work? ☐ Yes ☐ No

If yes, briefly explain ____

Are your symptoms worse while at work? ☐ Yes ☐ No

If yes, briefly explain

____

ANY ADDITIONAL INFORMATION YOU WOLD LIKE ME TO KNOW?

____

WHEN ARE YOUR SYMPTOMS WORSE ☐ Year-round

☐ January ☐ February ☐ March ☐ April ☐ May ☐ June

☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

MEDICATIONS

Do you take any of the following medications on a regular basis? (please circle)

Antihistamines (Benadryl, Actifed, Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp, Drixoral, Trimalin, Atarax, Claritin, Allegra, Zyrtec, etc.)

Bronchodilators (Albuterol, Ventolin, Proventil, Serevent, or OTS's such as Primatine Mist, etc.}

Steroid inhalers (Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair etc.}

Nasal Steroids (Beconase, Flonase, Nasacort, Rhinocort, etc.)

Medication that affect the immune system (Prednisone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus, etc.)

Chemotherapy

SMOKING

Do you smoke? ☐ Yes ☐ No

Number of cigarettes per day ________ At what age did you start? ____

Anyone smoke in your house? ☐ Yes ☐ No

FOOD RELATED SYMPTOMS

☐ Symptoms flare 5-60 minutes after meals

☐ The smell or odor of some foods increases symptoms

☐ Some foods cause swelling of the mouth or tongue

☐ Some foods are craved or addictive

☐ Some foods cause nasal symptoms

☐ Some foods cause rashes or hives

☐ Some foods cause upset stomach or vomiting

☐ Some foods cause diarrhea

☐ Symptoms occur with restaurant salad bars or Asian foods

☐ Some foods cause headaches

☐ Symptoms occur with any regularly eaten food

☐ Some foods cause asthma

☐ Preservatives, additives or food coloring increases symptoms

☐ No problem with foods

FOODS THAT CAUSES SYMPTOMS FROM ONE HOUR TO THREE DAYS AFTER EXPOSURE

☐ Eggs	☐ Milk	☐ Beef	☐ Corn	☐ Wheat	☐ Soybean
☐ Peanut	☐ Pork	☐ Fish	☐ Shellfish	☐ Orange/citrus	☐ Potato
☐ Tomato	☐ Yeast	☐ Chocolate	☐ Coffee/Tea	☐ None	☐ Other

CHEMICALS THAT CAUSE SYMPTOMS

☐ Insecticides & pesticides	☐ Paints &household cleaners	☐ Perfumes & cosmetics
☐ Gasoline & auto exhaust	☐ Stove or furnace emissions	☐ The smell of new fabrics or fabric store
☐ Chemicals in the work place	☐ Laundry detergent	☐ Newsprint

Other ____

None ____________

DID YOU SUFFER FROM ANY TYPE OF PHYSICAL, CHEMOCAL OR EMOTIONAL TRAUMA JUST BEFORE YOUR SYMPTOMS WERE FIRST OBSERVED?

____

HAVE YOUR SYMPTOMS EVER GONE AWAY FOR ANY PERIOD OF TIME?

____

PREVIOUS DIAGNOSIS OF ALLERGY?

☐ Yes, and allergy shots helped ☐ Did not help ☐ Yes, medication helped ☐ Did not help ☐ None

FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

☐ Mother ☐ Father ☐ Brother/Sister ☐ Grandparents

☐ Son/Daughter ☐ Spouse ☐ None

FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS

☐ Constant/Chronic with little change

☐ Present most of the time

☐ Present part of the time

☐ Present rarely

☐ Prevents some normal activities

☐ Considerable interference with normal life

☐ Slight interference with normal life

☐ No interference with normal life

SYMPTOMS ARE WORSE

☐ Outdoors and better indorse

☐ At nighttime

☐ In the bedroom or when in bed

☐ During windy weather

☐ During wet or damp weather

☐ When the weather changes

☐ During known pollen seasons

☐ In certain rooms or buildings

☐ When exposed to tobacco smoke

☐ With yard work, cut grass, leaves, hay or barns

☐ When sweeping or dusting the house

☐ In areas with mold or mildew

☐ In air conditioning

☐ In fields or in the country

☐ Tobacco smoke bothers me more than anything else

SYMPTOMS ARE BETTER

☐ After shower or bath ☐ In air conditioning ☐ Indoors

☐ During or after physical activity ☐ After taking antihistamines ☐ With allergy shots

What makes you feel better?

____

ANIMAL, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

☐ Dogs ☐ Cats ☐ Horses or Cattle

☐ Rabbits ☐ Birds or Feathers ☐ Rodents (mice, guinea pigs, etc.)

☐ Bees ☐ None ☐ Other ____

Have You Been Vaccinated Against Communicable Diseases ☐ Yes ☐ No

Have you experienced and adverse reactions or symptoms after vaccination administered ☐ Yes ☐ No

At what age were symptoms / reactions experienced _________

Name of Vaccine ____________________ (age in months, years) ____________________

Name of Vaccine ____________________ (age in months, years) ____________________

Name of Vaccine ____________________ (age in months, years) ____________________

PLEASE CHECK OFF THE FOLLOWING THAT APPLY TO YOU

Digestive Track

☐ nausea & vomiting

☐ diarrhea

☐ constipation

☐ bloated feeling

☐ stomach pains or cramps

☐ heart burn

☐ blood and/or mucous in stools

TOTAL ____

Ears

☐ itchy ears

☐ ear aches/ear infections

☐ drainage from ear

☐ ringing in ears

☐ hearing loss

Heart

☐ irregular/skipped heartbeat

☐ rapid/pounding heartbeat

☐ chest pain

TOTAL ____

Joints & muscles

☐ pains/aches in joints

☐ arthritis/osteoarthritis

☐ stiffness/limited movement

☐ pain/aches in muscles

☐ feeling weak/tired

☐ swollen/tender joints

☐ growing pains in legs

☐ psoriatic/gouty arthritis

TOTAL ____

Nose

☐ stuffy nose

☐ chronically red/inflamed nose

☐ sinus problems

☐ hay fever

☐ sneezing attacks

☐ excessive mucous formation

TOTAL ____

Skin

☐ acne

☐ itching

☐ hives/rash/dry skin

☐ hair loss

☐ flushing/hot flashes

TOTAL ____

☐ reddening of ears

TOTAL ____

Emotions

☐ mood swings

☐ anxiety/fear/nervousness

☐ anger/irritability/aggressiveness

☐ argumentative

☐ frustrated/cries easily

☐ depression

TOTAL ____

Eyes

☐ watery or itchy eyes

☐ red/swollen/itchy eyelids

☐ bags or dark circles under eyes

☐ blurred or tunnel vision

TOTAL ____

Head

☐ headaches

☐ faintness

☐ dizziness

☐ insomnia/sleep disorder

☐ facial flushing

TOTAL ____

Lungs

☐ chest congestion

☐ asthma/bronchitis

☐ shortness of breath

☐ difficult breathing

☐ persistent cough

☐ wheezing

TOTAL ____

Mind

☐ poor memory

☐ difficulty completing projects

☐ difficulty with mathematics

☐ underachiever

☐ poor/short attention

☐ confusion

☐ easily distracted

☐ difficulty making decisions

☐ learning disabilities

TOTAL ____

Mouth & Throat Thrush

☐ chronic coughing

☐ gagging/clearing throat often

☐ sore throat/hoarse voice/voice loss

Weight

☐ binge eating/drinking

☐ craving certain foods

☐ excessive weight

☐ compulsive eating

☐ water retention

TOTAL ____

Genitourinary

☐ kidney

☐ frequent/urgent urination

☐ bladder

☐ yeast infections

☐ genital itch/discharge/anal itching

☐ yeast infections

TOTAL ____

Other conditions

☐ Autism

☐ A.D.H.D.

☐ A.D.D.

☐ Psoriasis

☐ Eczema

☐ Auto Immune Disorder

☐ Chronic Fatigue

☐ swollen/discolored tongue/lips

☐ cancer sores

☐ itching on roof of mouth

TOTAL ____

☐ Multiple Chemical Sensitivities

☐ Asthma

☐ Congestive Heart Failure

☐ Sever Diabetes

☐ Severe Depression

☐ Obsessive Compulsive Disorder