Client Name:_____Date:_____

Address:_____City_____State_____Zip_____
Cell#_____MALE___FEMALE____DOB:_____
Email _____

Please answer the questions on this form as they relate to the person being evaluated.

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

We do not treat symptoms, illness, conditions or diseases. This is not a treatment for allergies, this does not diagnose allergies or relieve allergies A symptom is an attempt by your body to tell you something. We identify substances that may cause stress on the body and work to reduce substance specific stress using a combination of Low Level Light Therapy, Acupoint Stimulation, Homeopathy, Nutrition and Energetic Information to help bring the body back into balance We do not use drugs in this program. There is no single method that will work for everyone but this integrative approach can help increase your core lev-el energy, boost your immune system and help your body better deal with substance stressors leading to a higher quality of life Just because certain substances are considered "healthy" or "safe", this does not mean they are appropriate, "healthy" or "safe" for you. Your diet and environment consists of everything you ***eat, drink, rub on your skin,*** *or* ***inhale*** *Our procedures are safe, non-invasive and painless. If you suffer from anaphylaxis, we recommend you consult with your primary care physician for medical treatment appropriate for you. If you believe you suffer from allergies, we recommend you consult with your general practitioner, immunologist or board certified allergist before seeking alternative care.*

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

MEDICAL HISTORY REVIEW: Do you have problems with a heart valve, heart murmur, or congenital heart disease? Yes No If yes, please explain:

Do you have an illness that hinders your immune system? (Common Variable Immunodeficiency, HIV/AIDS, other Immunodeficiency) Yes No If yes, please specify:

Do you have an autoimmune disease? (Lupus, Rheumatoid Arthritis, Sarcoid, Scleroderma, etc.) Yes No If yes, please specify:

Do you have cancer? (Lymphoma, Leukemia, Multiple Myeloma, other)
Yes No
If yes, please specify:

Have you ever had a bone marrow or solid organ transplant? (Lung, Kidney, Liver)
Yes No
If yes, please specify:

Do you have problems with your spleen, lack of spleen or sickle cell anemia?
Yes No
If yes, please specify:

Do you have chronic back pain, problems with your discs, sciatica or carpel tunnel?
Yes No
If yes, please specify:

Do you have recurrent or chronic problems with any of the following?

(please check those that apply)

____Frequent Headaches
____Chest pain
____Heartburn/Reflux
____Pneumonia ____Vision Disturbance/Cataracts
____Constipation ____Wear Glasses ____High Blood Pressure ____Diarrhea
____Wear Contacts/Soft/GasPerm
____Rapid Heart Beat
____Frequent/Painful Urination
____Frequent Colds, /Year
____Nausea/Vomiting
____Arthritis
____Diabetes/Kidney Disease
____Bladder Disease
____Cancer
____Anemia/Blood Disorder ____Liver Disease/Hepatitis____Hea rrt Problems/Murmur
____Gynecologic Problems ____Glaucoma
Hay Fever ____Asthma
Osteoporosis
____Seizures Migraines
____Anxiety ____Thyroid Disease ____Peptic Ulcer

____Loss of Hearing
____Emphysema
____Depression

If yes to any above, please explain:

PREVIOUS AGE ISSUES FIRST OBSERVED DIAGNOSIS OF ALLERGY

☐ Infant (Age 0 – 2)
☐ Yes, and allergy shots helped. ☐ Child (Age 3 – 5)
☐ Yes, but allergy shots did not help ☐ Child (Age 6 – 12)
☐ Yes, and medication helped ☐ Adolescent (Age 13 – 18)
☐ Yes, but medication did not help ☐ Adult (Age 19 – 25)
☐ None ☐ Adult (Age 26 – 40) ☐ Adult (Age 40)

FAMILY MEMBERS WITH DIAGNOSED ALLERGIES

☐ Mother ☐ Father ☐ Brother/Sister ☐ Grandparents ☐ Son/Daughter ☐ Spouse ☐ None

EARS

☐ Itching ☐ Blocking, Fullness or Popping ☐ Pain ☐ Frequent Ear Infections ☐ Hearing Loss ☐ Ear Tubes ☐ Ringing In Ears ☐ None

THROAT & MOUTH

☐ Itching of Throat or Mouth ☐ Frequent Sore Throat ☐ Frequent Laryngitis ☐ Frequent Tonsillitis ☐ Mouth Sores ☐ Swelling of the Tongue or Mouth ☐ None

EYE

☐ Itching ☐ Excessive Watering ☐ Redness ☐ Swelling ☐ Above are worse during pollen seasons ☐ Above are worse with animal exposure ☐ Tobacco smoke/chemical exposure

SKIN ☐ Rashes ☐ Itching ☐ Eczema ☐ Hives ☐ Eczema ☐ Swelling ☐ Sores ☐

knees or elbows ☐ Above are worse during known
pollen seasons ☐ Above are worse with animal
exposure ☐ Skin problems are rare ☐ Skin problems are chronic ☐
None

NASAL

☐ Sneezing
☐ Itching ☐ Running Nose-Clear Discharge ☐ Runny Nose ☐ Stuffiness ☐ Post Blowing ☐ Above are worse during pollen season ☐worse with animal exposure
☐
☐ Nasal Drip ☐ Frequent Sinus Infections ☐ Nasal Obstruction ☐ Frequent Nose

CHRONIC GASTROINTESTINAL

☐ Nausea and Vomiting ☐ Diarrhea ☐ Gas, Heartburn ☐ Cramps or Bloating ☐ Abdominal Pain ☐ Re-taste Foods ☐ None

LUNG: ☐ Chest Congestion ☐ Shortness of Breath ☐ Difficulty Breathing ☐ Persistent Cough ☐ Wheezing ☐ None

DIGEST

Nausea & Vomiting ☐ Diarrhea ☐ Constipation ☐ Bloated Feeling ☐ Stomach pains or Cramps ☐ Heart Burn ☐ None

BONE & JOINT

☐ Joint or Bone Pain ☐ Muscle Pain ☐ Redness or Swelling of Joints ☐ Joint stiff

EMOTIONS

☐ Mood Swings ☐ Anxiety/Fear/Nervousness ☐ Anger/Irritability/Aggressiveness ☐ Argumentative ☐ Depressed ☐ None

HEART ☐ Irregular/Skipped Heartbeat ☐ Rapid /Pounding Heartbeat ☐ Chest Pain ☐ High Blood Pressure ☐ None

TOXICITY

☐ Frequent Headaches ☐ Skin Issues ☐ Constipation ☐ Foggy Thinking ☐ Dark Yellow or Orange Urine ☐ None

WEIGHT ☐ Binge eating/drinking

☐ Excessive Weight ☐ Compulsive Eating ☐ Craving Certain Foods ☐ Water Retention ☐ Want To Lose 10+lbs ☐ Cannot lose weight no matter what I eat or do ☐ None

HOST (parasite)

Itchy Ears, Nose, Anus ☐ Bloating, Gas, Digestive Problems ☐ TMJ and/or Grind Teeth ☐ Constipation or Diarrhea ☐ Low Energy/Low Stamina ☐ Joint & Muscle Pains ☐ Depressed ☐ None

ADRENAL

Crave for Salty, Fatty, High Protein Foods ☐ Get Dizzy when Stand Up

Quickly ☐ I am Tired when I Awake in Morning ☐ Irregular Sleep/Insomnia ☐ Frequent Sore Throat &/or Laryngitis ☐ Reduced Sex Drive ☐ Feeling Overwhelmed, Depressed

THYROID ☐ Weight gain/ Unable to lose weight with diet/exercise ☐ Fatigued, exhausted ☐ I feel Depressed, no motivation, moody ☐ Dry Skin ☐ Constipation ☐ Lost outer edge of Eye Brow ☐ Hair is Course, dry, brittle, falling out

HORMONE SYMPTOMS

☐ Fatigue ☐ Tightness ☐ Sleep issues/Insomnia ☐ Poor Memory ☐ Joint/muscle Pain ☐ Weight Gain ☐ Low Thyroid function ☐ Allergies ☐ Foggy Thinking ☐ Asthma or Wheezing with exercise ☐ Asthma or Wheezing when around animals ☐ Asthma or Wheezing during pollen seasons ☐ Asthma or Wheeze when around smoke or chemicals ☐ Shortness of Breath ☐

DEHYDRATION

☐ Wet Coughing ☐ Emphysema ☐ Dark Urine or Little Urination ☐ Frequent Bronchitis ☐ Walk on outside edge of feet ☐ Foggy Thinking or light headedness ☐ Recurring Pneumonia ☐ Chest Pain ☐ None ☐ Dry Mouth, Dry Skin ☐ Muscle Cramps ☐ Ankle swelling

OTHER ☐ ADD/ADHD ☐ Autism/Aspergers ☐ Auto-Immune ☐ Chronic Fatigue/ Fibromyalgia ☐ Multiple Chemical Sensitivity ☐ Severe Depression ☐ Obsessive Compulsive Disorder

FREQUENCY & SEVERITY OF SYMPTOMS

☐ Constant, Chronic with Little Change ☐ Present Most of the Time ☐ Present Part of the Time ☐ Present Rarely ☐ No Interference with Normal Life ☐ Slight Interference with Normal Life ☐ Considerable Interference with Normal ☐ Prevents Some Normal Activities

I FEEL WORSE or FEEL BETTER

☐ Outdoors, and better indoors
☐ After Shower or Bath ☐ At nighttime
☐ In Air Conditioning ☐ In the bedroom or when in bed
☐ Indoors ☐ During windy weather
☐ During or After Physical Activity ☐ During wet or damp weather
☐ When the weather changes
☐ After Taking Antihistamines ☐ With Allergy Shots
☐ With Allergy Shots ☐ During known pollen seasons
☐ When Away from Home ☐ In certain rooms or buildings
☐ When At Home ☐ When exposed to tobacco smoke
☐ When not at Work ☐ With yard work, cut grass,
☐ Don't Know 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 ☐ Don't know

I REACT WHEN IN PROXIMITY OR DURING EXPOSURE TO:

☐ Dogs ☐ Cats ☐ Horses or Cattle ☐ Rodents (mice, guinea pigs, etc.) ☐ Rabbits ☐ Birds or Feathers ☐ Bees ☐ Other: ☐ None

<u>FOOD RELATED</u>

☐ Discomfort occurs 5 – 60 minutes after meals ☐ Some foods are craved or addictive ☐ The smell or odor of some foods increases discomfort ☐ Preservatives, additives or food colorings increase discomfort ☐ Some foods cause nasal reactions ☐ Some foods cause tightness in chest, wheezing, difficulty breathing etc. ☐ Some foods cause rashes or hives ☐ Some foods cause headaches ☐ Some foods cause swelling of mouth or tongue ☐

Some foods cause upset stomach or vomiting ☐ Some foods cause diarrhea ☐ Discomfort occurs with restaurant salad bars or Asian foods ☐ Discomfort occurs with any regularly eaten food ☐ None

FOODS THAT CAUSE DISCOMFORT WHEN CONSUMED (1 to 2 hrs later)

☐

☐ Eggs ☐ Milk ☐ Beef ☐ Corn
☐ Wheat ☐ Soybean ☐ Peanut
☐ Pork ☐ Fish ☐ Shellfish ☐
Orange or Other Citrus ☐ Potato
☐ Tomato ☐ Yeast ☐ Chocolate
☐ Coffee or Tea ☐ Other:

Pork ☐ Fish ☐ Shellfish ☐
Orange or Other Citrus ☐ Potato
☐ Tomato ☐ Yeast ☐ Chocolate
☐ Coffee or Tea ☐ Other:

WITHIN 3-24 HOURS

☐ Eggs ☐ MilkBeef
☐ Corn ☐ Wheat
☐ Soybean ☐ Peanut

CHEMICALS I'M SENSITIVE TO:

☐ Insecticides & Pesticides ☐ Paints & Household Cleaners ☐ Perfumes & Cosmetics ☐ Gasoline or Automobile Exhaust ☐ Stove or Furnace Emissions ☐ The Smell of New Fabrics or Fabric Stores ☐ Chemicals in the Workplace ☐ Laundry Detergent ☐ Newsprint ☐ Other: ☐ None

I FEEL WORSE:

☐ Year Round

Or in these months?

_____

Have you had your tonsils or adenoids removed?
Yes/ No

Have you had ear, nose or sinus surgery?
Yes/ No If yes, please explain:

What is your current weight?
What was your weight 1 year ago?

When was your last chest x-ray? Results?

Have you ever had sinus x-rays? Yes No If yes, please explain:

MEDICATIONS:

Do you take any medications on a regular basis? Supplements? Please explain

_____

_____

_____

☐ *Married* ☐ *Divorced* ☐ *Widowed*

SOCIAL:

Where were you born? Where were you raised?

Where have you lived?

Check which one applies: ☐

Single

drinks/day _____

SMOKING:

Do you presently smoke? Yes No If yes, average number of cigarettes per day: If yes, at what age did you start? Have you ever smoked? Yes No If yes, how many years? When did you quit? Average number of cigarettes you smoked per day: Does anyone smoke in your home? Yes No Do you want to quit smoking? Yes No If Yes, why?

PREVIOUS ALLERGY DIAGNOSIS:

Have you ever seen an allergist? Yes No If yes, allergist's name: Have you had allergy skin testing? Yes No If yes, Date: Did you have any positive reactions? Yes No If yes, please list positive allergens (include any medications):

Have you ever received allergy injections? Yes No If yes, did your symptoms improve while receiving injections? Yes No Have you ever experienced an adverse reaction to an allergy injection? Yes No If yes, please explain:

Have you ever received Cortisone? (Prednisone, Methylprednisolone, etc.) drugs? Yes No If yes, how long ago? How much?

ENVIRONMENTAL SURVEY:

Do your discomforts disturb your sleep? Yes/ No Do you feel better when away from home? Yes/ No
How long have you lived in your house/apartment/condo?

Do you live in a:

☐ House ☐ Apartment/Duplex ☐ Condominium/Townhouse Approximately how old is your house/apartment/condo? Do you live in:

- ☐The City
- ☐The Suburbs
- ☐Rural Area

Do you have a basement? Yes/ No Is your house built on a slab? Yes /No

(radiator) ☐ Electric ☐ Hot Water (baseboard)

Type of heating system:

☐ Hot Air ☐ Steam

PETS: *(This section only for those who own any pets)*

What type of surface in the home?

☐ Carpeted ☐ Tile ☐ Other

Are there any animals in your home? Cats? Dogs? Other? Yes/ No Have you missed school or work due to reactions or sensitivities? Yes /No If yes, how many days did you miss last year because of them?

WORK ENVIRONMENT:

What is your occupation? Where are you employed? How long have you worked there?

commute time? old or new building? carpet or tile in office?

Is there air conditioning? Yes /No Is
smoking permitted? Yes/ No

Are you exposed to chemicals or strong odors?
Yes /No

If yes, briefly
explain:

Do you feel worse while at work? Yes No If yes, briefly explain:

Have you missed time from work due to reactions or sensitivities?
Yes/ No

If yes, how much time have you missed in the past
year?

ADDITIONAL INFORMATION *Please use this page to fill out any additional information that you feel may be pertinent.*

IF THE PATIENT IS A CHILD, PLEASE COMPLETE THE FOLLOWING:

Place of Birth:
Mother's Age at
Birth:

Was Pregnancy/Labor/Delivery Normal? Yes
No If no, please explain:

Birth Weight:
Formula or Breast
Fed? Well
Tolerated?
Has child reached normal growth milestones? Yes/ No _____If no, please explain:
Your relationship to
child:

Birth Weight:
Formula or Breast Fed? Well Tolerated?

Has child reached normal growth milestones?
Yes No If no, please explain:

Your relationship to child: