Dr. Poane's Chiropractic Office
Dr. Robert Poane 1 One Barrington Pl., Suite 108, Bel Air, Maryland 21014

NEW PATIENT ALLERGY & SENSITIVITY SYMPTOM QUESTIONNAIRE

Patient Name: _____ **Gender: male / female** **Date:** _____

Address: _____ **Date of Birth:** _____

Home#: _____ **Work#** _____

Referring Physician, Person or media that referred you to us? _____

Primary Care Physician: _____ **Allergist:** _____

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 or diseases. We address the nervous system which is responsible for symptoms.*
- *Allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use drugs in this program, however nutrition or homeopathic might be recommended.*
- *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, breath in, or rub on your skin**.*
- *Our procedures are safe and painless.*

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

_____

Please finish this statement: "My symptoms started ever since _____"

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1. Your age now: _____ Your age when symptoms were first observed: _____

2. Did you suffer from or did you observe someone else suffering from, <u>any type</u> of trauma days or months before the symptoms began? _____

3. Have your symptoms ever gone away for a period of time? _____

4. What state or country did you first notice the symptoms? _____

5. Have you ever traveled out of the country or to an island? _____

6. FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

Mother Father Brother/Sister Grandparents Son/Daughter Spouse None

7. Please answer all: Do you carry an Epi pen? Yes / No

Were you ever advised to carry an Epi pen? Yes / No
Were you ever told that you had an 'anaphylactic reaction? Yes / No
Have you ever had an anaphylactic reaction? Yes / No
Has your throat ever closed or nearly closed due to an allergic reaction? Yes / No

8. If you are susceptible to an anaphylactic reaction, what will bring it on? i.e. shell fish, peanuts, etc…: _____?

9. Do you have a current medical condition, i.e. MS, epilepsy, diabetes, lupus? No / Yes

10. Are you pregnant? No / Yes

11. When do the symptoms occur? daily, when I wake up, morning, afternoon, or night

12. What time of year are the symptoms worse? winter, spring, summer, fall

13. How long does it take you to notice the symptoms after exposure? within minutes, hours, 2-3 days?

14. What makes you feel better? _____

15. What animals, insects, birds, etc… cause your symptoms?_____

16. What foods cause or you think cause your symptoms? _____

17. Do you notice the symptoms when you are around wet or damp places? _____

18. Were you previously diagnosed with allergies by an allergist or family doctor? _____

Did you ever get allergy injections? ☐ Yes ☐ No Have you had allergy Blood testing? Yes / No

Have you had allergy skin testing? Yes / No If yes, do you have the results? _____

19. What medication are you taking for your heartburn, GERD, stomach or intestinal symptoms? _____

20. Do you take any of the following medications on a regular basis?

☐ 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)

☐ Medications affecting the immune system (Prednisone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus

☐ Chemotherapy

Please list medications not mentioned above that you are currently taking: _____

21. Do you smoke? no / yes Are you around smoke in your home or work environment? ☐ Yes ☐ No

22. WORK ENVIRONMENT: What is your occupation? _____

Are you exposed to chemicals or strong odors at work? ☐ Yes ☐ No If yes, briefly explain _____

_____

23. What are your hobbies? _____

24. What are the hobbies AND occupation of the people you live with?

_____

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Diplomate of the American Chiropractic Rehabilitation Board
Advanced Allergy Therapeutics Practitioner
Book Author: Troubleshooting Back Pain

Waiver, Release and Informed Consent

I _____, hereby consent to treatment at Dr. Poane's Chiropractic Office, consisting of, but not limited to Neurologic Stress Reduction (NSR), Emotional Freedom Technique (EFT), homeopathic remedies, nutrition, ionic detoxification foot bath and chiropractic manipulation.

I understand I am not being treated for allergies or sensitivities. I understand that I am being treated to reduce stress off my nervous system in hopes that my body will no longer produce symptoms associated with my main complaint.

I understand that this service is not covered by my insurance company.

I understand one of the risks with natural treatment is detoxification. Detoxification symptoms can be in the form of flu like symptoms, rashes or other uncomfortable sensations. These usually resolve in a day or two.

Should symptoms develop in the course of treatment, I agree to seek immediate medical attention if I feel the need. This office and all of its employees assume no responsibility for medical conditions requiring the attention of a medical doctor, or necessary adjustments to prescribed medications during or after the completion of treatment.

I understand this type of treatment is not guaranteed. While symptoms might subside in whole or in part due to neurologic re-programming, I understand that symptoms may re-develop in the future.

THERE REMAINS AN INHERENT RISK OF PROVOKING AN ANAPHYLACTIC REACTION ANYTIME THE BODY 'BELIEVES' IT IS INTRODUCED TO A THREATENING ALLERGEN. I AM WILLING TO TAKE THAT RISK.

I admit and confess that I understand the above information concerning treatment rendered to me by Dr. Robert Poane. I hereby consent to said treatment.

IN WITNESS THEREOF, the undersigned executed the Agreement on (today's date): _____

_____ Print Name of Patient

_____ Print Name of Parent or Legal Guardian

_____ Signature of Patient / Undersigned

_____ Signature or Parent or Legal Guardian

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Biopsychosocial

Name:_____ Date: _____

Social :

1. What is your occupation?
2. Have you lost work because of this condition? ___ If yes, how many days or what dates? _____
3. Is this condition due to injury or sickness arising out of employment? _____ auto accident? ___ other?__
4. Do you exercise? If so, where and what type:
5. Do you smoke? no / yes packs / day? _____ No. of years? _____
6. Do you drink alcohol? no / yes = heavy moderate light times per week_____
7. Do you have small children: no / yes how many?_____
8. Have you ever been in an auto accident? No / yes = When?_____
9. Have you ever seriously injured yourself from a fall or other trauma? _____
10. What operations have you had and when? _____
11. Serious illness and when? _____

Circle your sleeping position(s): stomach, half stomach half side with one knee up, back, side
Do you sit at a desk frequently? Yes / No
Does your back hurt when you vacuum? Yes / No
Do you drive more than 20 minutes per day on the high way? Yes / No
Do you have to lift or reach for items (any items) on a daily basis? Yes / No

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REVIEW OF SYSTEMS:

Please explain any "YES" answers

Do you have or have you had significant problems with (your):

1. Eyes, ears, nose or mouth? no / yes _____
2. Heart or lungs? no / yes _____
3. Stomach, digestion (heart burn, indigestion), bowels, bowel movement or gastrointestinal tract? no / yes _____
4. Genitourinary system: please circle symptoms or conditions you now have or have in the past:
   Female: fibroids, breast pain, cancer, PMS, pain associated with period, frequent yeast infections, _____
   Male: urinary difficulties, difficulty stopping or starting urination, prostate enlargement, cancer etc? _____
5. Muscles, ligaments, bones, arthritis, ...? no / yes _____
6. Nerves, i.e. MS, pinched nerve, shaking, tripping, unsteady walk....? no / yes _____
7. Skin , sores, wound care, ...? no / yes _____
8. Psychiatric, i.e. bipolar, frequent depression,.....? no / yes _____
9. Do you seek professional counseling? no / yes _____
10. Is stress a factor in your life?_____
11. Hormone issues, lupus, autoimmune conditions, diabetes? _____
12. Blood or lymphatic problems? no / yes_____
13. Are you currently loosing weight for unknown reasons? no / yes_____
14. Do you have allergies or sensitivities to anything? no / yes _____
15. Other?_____

Family History:

1. Are there health related conditions that run or may run in your family, i.e. back problems, heart disease, cancer, alcohol, etc.. ? no / yes - explain:
2. Does or did your mother, father or siblings have allergies or sensitivities?

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check **only** the ***symptom(s)*** and known ***allergen(s) and symptom triggers*** that brought you to our office today:

	Yes			Yes	
		Symptoms			***Allergens***
		Irritable Bowel (IBS)			Eggs
		Bloating			Milk / dairy / cheese
		Constipation / diarrhea			Corn
		Stomach / intestinal pains or cramps			Sugar
		Heart burn			Wheat / grains / bread
					Soy
		Reddening of ears			Fruit
		Ringing in ears			Vegetables
		Ear aches / ear infections			Chocolate
					Coffee / tea
		Sinusitis			Meat / beef / chicken / pork
		Stuffy nose / runny nose			Fish: shellfish / other fish
		Hay fever			Peanut
		Sneezing attacks			Tomato
		Excessive mucus / clearing throat			Yeast
					Wine
		Asthma			Artificial: coloring / preservatives / flavors
		Chronic cough			
		Sore throats			Pollen / trees /grass / weeds (ragweed - hay fever)
		Hoarse voice/loss voice			Flowers / plants
		Tingling lips			
					Mold / mildew / fungus
		Acne			Dust / dust mites
		Eczema / Psoriasis			
		Itching skin			Chemical sensitivities
		Hives/rash/dry skin			Cleaning products
					Personal care products: deodorant / make up, etc…
		Hot flashes			Perfume: the kind you put on your skin
		PMS/painful menstruation			Scented candles / odors / smells
		Chronic yeast infections			Toilet paper
		Watery itchy eyes			Things you touch: metal / paper / ink / latex / fabric
		Red/swollen/itchy/eyelids			
		Dark circles under eyes			Animals: cat / dog / other
					Sun
		Headache			Medication
		Dizziness			Other allergens:
		Irregular heart beat			Other conditions and symptoms:
					MS
		Mood swings			Lupus
		Depression			Autism
		Anger/fear/nervousness			Autoimmune disorder
		Fatigue			ADD / ADHD
		Other symptoms:			Obsessive compulsive disorder (OCD)