Clinic Intake Form

Patient Name: ______________________________ **Date:** ______________________

Address: ______________________________ **Date of Birth:** ______________________

City, State, Zip: ______________________________ **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 for us that you understand:

- *We 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.*
- *We will attempt to find the underlining cause.*
- *We 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****.*
- *Our 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? _____

WORK ENVIRONMENT:

What is your occupation? _________________________ Are you exposed to chemicals or strong odors at work? _______

If yes, briefly explain _________________________________ Are your symptoms worse while at work? ______________

If yes, briefly explain ____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE US 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?

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

Please list any medications that you are currently taking: ____

SMOKING:

Do you smoke?___ Number of cigarettes per day ____ At what age did you start? ___ Anyone smoke in your house? ___

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 causes upset stomach or vomiting

€ Symptoms occur with restaurant salad bars or Asian foods

€ Some foods are craved or addictive

€ Some foods cause nasal symptoms

€ Some foods cause rashes or hives

€ Some foods cause diarrhea

€ Some foods causes 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 SYMPTOM(S) 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, CHEMICAL 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 indoors

€ In the bedroom or when in bed

€ During wet or damp weather

€ During known pollen seasons

€ When exposed to tobacco smoke

€ When sweeping or dusting the house

€ In air conditioning

€ Tobacco smoke bothers me more than anything else

€ At nighttime

€ During windy weather

€ When the weather changes

€ In certain rooms or buildings

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

€ In areas with mold or mildew

€ In fields or in the country

SYMPTOMS ARE BETTER:

€ After shower or bath

€ During or after physical activity

€ In air conditioning

€ After taking antihistamines

€ Indoors

€ With allergy shots

What makes you feel better? ____

ANIMAL, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE:

€ Dogs

€ Rabbits

€ Bees

€ Cats

€ Birds or Feathers

€ None

€ Horses or Cattle

€ Rodents (mice, guinea pigs, etc.)

€ Other ____

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

€ 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

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 ____

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

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 ____

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

€ blurred or tunnel vision

TOTAL ____

Head

€ headaches

€ faintness

€ dizziness

€ insomnia/sleep disorder

€ facial flushing

TOTAL ____

€ confusion

€ easily distracted

€ difficulty making decisions

€ learning disabilities

TOTAL ____

Mouth & Throat Thrush

€ chronic coughing

€ gagging/clearing throat often

€ sore throat/hoarse voice/voice loss

€ swollen/discolored tongue/lips

€ cancer sores

€ itching on roof of mouth

TOTAL ____

TOTAL ____

Other conditions

€ Autism

€ A.D.H.D.

€ A.D.D.

€ Psoriasis

€ Eczema

€ Auto Immune Disorder

€ Chronic Fatigue

€ Multiple Chemical Sensitivities

€ Asthma

€ Congestive Heart Failure

€ Sever Diabetes

€ Severe Depression

€ Obsessive Compulsive Disorder