

COMPREHENSIVE INTAKE QUESTIONNAIRE

Patient Name: _____ Date: _____
Address: _____ Date of Birth: _____
City, State, Zip: _____ Home #: _____
Gender (circle one): MALE FEMALE Work #: _____
Primary Care Physician: _____ Referring Physician: _____
Insurance: _____

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 level 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 recommended you consult 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: _____

COMPREHENSIVE INTAKE QUESTIONNAIRE

Do you have an illness that effects 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 carpal tunnel? Yes No

If yes, please specify: _____

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

(please check those that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heartburn/Reflux |
| <input type="checkbox"/> Vision Disturbance/Cataracts | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Wear Glasses | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Wear Contacts/Soft/Gas Perm | <input type="checkbox"/> Rapid Heart Beat | <input type="checkbox"/> Frequent/Painful Urination |
| <input type="checkbox"/> Frequent Colds, ____/Year | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney/Bladder Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Anemia/Blood Disorder | <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Heart Problems/Murmur |
| <input type="checkbox"/> Gynecologic Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Arthritis |

If yes to any above, please explain: _____

Briefly explain any other chronic symptoms: _____

AGE WHEN ISSUES WERE FIRST OBSERVED

- Infant (Age 0 – 2)
- Child (Age 3 – 5)
- Child (Age 6 – 12)
- Adolescent (Age 13 – 18)
- Adult (Age 19 – 25)
- Adult (Age 26 – 40)
- Adult (Age 40)

FAMILY MEMBERS WITH DIAGNOSED ALLERGIES

- Mother
- Father
- Brother/Sister
- Grandparents
- Son/Daughter
- Spouse
- none

SKIN

- Hives
- Rashes
- Itching
- Eczema
- Swelling
- Sores
- Once had rashes in the bends of 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

EYE

- Itching
- Excessive Watering
- Redness
- Swelling
- Above are worse during pollen seasons
- Above are worse with animal exposure
- Tobacco smoke/chemical exp makes me feel worse
- none

PREVIOUS DIAGNOSIS OF ALLERGY

- Yes, and allergy shots helped.
- Yes, but allergy shots did not help
- Yes, and medication helped
- Yes, but medication did not help
- none

EAR

- Itching
- Blocking, Fullness or Popping
- Pain
- Frequent Ear Infections
- Hearing Loss
- Ear Tubs
- Ringing In Ears

NASAL

- Itching
- Sneezing
- Running Nose-Clear Discharge
- Frequent Nose Blowing
- Above are worse during pollen exposure
- Above are worse with animal exposure
- Runny Nose – Cloudy Discharge
- Stuffiness
- Post Nasal Drip
- Frequent sinus Infections
- Nasal Obstruction
- Loss of Smell

THROAT & MOUTH

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

CHRONIC GASTROINTESTINAL

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

DIGESTIVE TRACK

- Nausea & Vomiting
- Diarrhea
- Constipation
- Bloating Feeling
- Stomach pains or Cramps
- Heart Burn

EMOTIONS

- Mood Swings
- Anxiety/Fear/Nervousness
- Anger/Irritability/Aggressiveness
- Argumentative
- Depressed

TOXICITY

- Frequent Headaches
- Skin Issues
- Constipation
- Foggy Thinking
- Dark Yellow or Orange Urine

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

OTHER

BONE & JOINT

- Joint or Bone Pain
- Muscle Pain
- Redness or Swelling of Joints
- Joint Stiff, Limited Motion

LUNGS

- Chest Congestion
- Asthma/bronchitis
- Shortness of Breath
- Difficulty Breathing
- Persistent Cough
- Wheezing

HEART

- Irregular/Skipped Heartbeat
- Rapid /Pounding Heartbeat
- Chest Pain
- High Blood Pressure

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

ADRENAL

- Crave for Salty, Fatty, High Protein foods
- Get Dizzy when Stand Up Quickly
- I am Tired when I Awake in Morning
- Frequent Sore Throat &/or Laryngitis
- Reduced Sex Drive
- Feeling Overwhelmed, Depressed
- Irregular Sleep/Insomnia

THYROID

COMPREHENSIVE INTAKE QUESTIONNAIRE

- ADD/ADHD
- Autism/Asbergers
- Auto Immune _____
- Chronic Fatigue/ Fibromyalgia
- Multiple Chemical Sensitivity
- Severe Depression
- Obsessive Compulsive Disorder.

- 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

- Fatigue
- Sleep issues/Insomnia
- Poor Memory
- Joint/muscle Pain
- Weight Gain
- Low Thyroid function
- Allergies
- Foggy Thinking

DEHYDRATION

- Dark Urine or Little Urination
- Walk on outside edge of feet
- Foggy Thinking or light headedness
- Dry Mouth, Dry Skin
- Muscle Cramps
- Ankle swelling

CHEST SYMPTOMS

- Tightness
- Asthma or Wheezing with exercise
- Asthma or Wheezing when around animals
- Asthma or Wheezing during pollen seasons
- Asthma or Wheeze when around tob smoke or chemicals
- Shortness of Breath
- Dry Coughing
- Wet Coughing
- Emphysema
- Frequent Bronchitis
- Recurring Pneumonia
- Chest Pain
- none

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 Life
- Prevents Some Normal Activities

I FEEL WORSE

- Outdoors, and better indoors
- 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

I FEEL BETTER

- After Shower or Bath
- In Air Conditioning
- Indoors
- During or After Physical Activitiy
- After Taking Antihistamines
- With Allergy Shots
- When Away from Home
- When At Home

I FEEL WORSE

- When exposed to tobacco smoke

I FEEL BETTER

- When I go out of Town

COMPREHENSIVE INTAKE QUESTIONNAIRE

- 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
- Don't know
- When not at Work
- When at Home
- When away from Home
- 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

FOOD RELATED

- 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 CONSUMMED :

WITHIN 1-2 HOURS

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

WITHIN 3-24 HOURS

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

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

- | | | |
|----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> January | <input type="checkbox"/> February | <input type="checkbox"/> March |
| <input type="checkbox"/> April | <input type="checkbox"/> May | <input type="checkbox"/> June |
| <input type="checkbox"/> July | <input type="checkbox"/> August | <input type="checkbox"/> September |
| <input type="checkbox"/> October | <input type="checkbox"/> November | <input type="checkbox"/> December |

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? (check one) Yes No If yes, please explain: _____

MEDICATIONS:

COMPREHENSIVE INTAKE QUESTIONNAIRE

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 that effect the immune system
(Prednisone, Imuran, Methotrexate, Cellcept, Cytoxan, Cyclosporine, Tacrolimus,
 - Chemotherapy
- Please list any medications you are currently taking: _____

SOCIAL:

Where were you born? _____ Where were you raised? _____
Where have you lived? _____

Check which one applies: Single Married Divorced Widowed

How many children do you have? _____ What are their ages? _____

Do you exercise? Yes No If yes, how often? _____/week How long? _____/workout

Do you drink alcohol? Yes No If yes, how often? _____times/week How much? _____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 many years 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

Type of heating system: Hot Air Steam (radiator) Electric Hot Water (baseboard)

Do you have: Wood/Coal Stove Humidifier Dehumidifier Air Cleaner

PETS:

(This section only for those who own any pets)

How many of the following pets do you own?

Cats _____ Dogs _____ Birds _____ Other _____

Are they indoor or outdoor pets? _____ Sensitive reaction to Animals Yes No _____

SCHOOL HISTORY:

Do you attend school? Yes No If yes, at what grade level? _____

Is your classroom: Carpeted Tile Other _____ Are there any animals in your classroom? Yes No

Have you missed school 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? _____ Is your workplace: Carpeted Tile Other

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? _____

Mark The Ones That Apply to You:

COLD SYNDROME

- Aversion to cold and preference for warmth
- Tastelessness in the mouth
- Absence of thirst; pallor & Cold extremities
- Clear and profuse urine
- Loose stool
- Pale tongue proper with a white slippery coating
- Slow pulse

HOT SYNDROME

- Feverish and preference for cooling
- Preference for cold
- Flushed cheeks and redness of the eyes
- Yellowish and scanty urine
- Constipation
- Red tongue proper with a dry yellowish coating
- Rapid pulse,

