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COMPREHENSIVE INTAKE QUESTIONNAIRE

Patient Name: _____ Date: _____
Address: _____ Date of Birth: _____
City, State, Zip: _____ Home #: _____
Gender: ☐ 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? Select
If yes, please explain:

COMPREHENSIVE INTAKE QUESTIONNAIRE

Do you have an illness that effects your immune system? (Common Variable Immunodeficiency, HIV/AIDS, other Immunodeficiency) Select If yes, please specify: _____

Do you have an autoimmune disease? (Lupus, Rheumatoid Arthritis, Sarcoid, Scleroderma, etc.) Select

If yes, please specify: _____

Do you have cancer? (Lymphoma, Leukemia, Multiple Myeloma, other) Select

If yes, please specify: _____

Have you ever had a bone marrow or solid organ transplant? (Lung, Kidney, Liver) Select

If yes, please specify: _____

Do you have problems with your spleen, lack of spleen or sickle cell anemia? Select

If yes, please specify:_____

Do you have chronic back pain, problems with your discs, sciatica or carpel tunnel? Select

If yes, please specify: _____

Do you have recurrent or chronic problems with any of the following? (please check those that apply)

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

If yes to any above, please explain:

Briefly explain any other chronic symptoms:

Describe any and all emotional Trauma's in your life:

COMPREHENSIVE INTAKE QUESTIONNAIRE

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)

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

FAMILY MEMBERS WITH DIAGNOSED ALLERGIES

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

EAR

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

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

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

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

THROAT & MOUTH

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

COMPREHENSIVE INTAKE QUESTIONNAIRE

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

BONE & JOINT
- ☐ Joint or Bone Pain
- ☐ Muscle Pain
- ☐ Redness or Swelling of Joints
- ☐ Joint Stiff, Limited Motion

DIGESTIVE TRACK
- ☐ Nausea & Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloated Feeling
- ☐ Stomach pains or Cramps
- ☐ Heart Burn

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

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

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

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

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

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

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

COMPREHENSIVE INTAKE QUESTIONNAIRE

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

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
- ☐ 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 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

COMPREHENSIVE INTAKE QUESTIONNAIRE

I FEEL WORSE

- ☐ 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
- ☐ Don't know

I FEEL BETTER

- ☐ When I go out of Town
- ☐ 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

COMPREHENSIVE INTAKE QUESTIONNAIRE

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

- ☐ January
- ☐ February
- ☐ March
- ☐ April
- ☐ May
- ☐ June
- ☐ July
- ☐ August
- ☐ September
- ☐ October
- ☐ November
- ☐ December

Have you had your tonsils or adenoids removed? Select
Have you had ear, nose or sinus surgery? Select
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) Select If yes, please explain:

COMPREHENSIVE INTAKE QUESTIONNAIRE

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.)

☐ 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? Select If yes, how often? _____/week How long? _____/workout

Do you drink alcohol? Select If yes, how often? _____times/week How much? _____drinks/day

SMOKING:

Do you presently smoke? Select If yes, average number of cigarettes per day: _____

If yes, at what age did you start? _____

Have you ever smoked? Select If yes, how many years? _____ When did you quit? _____

Average number of cigarettes you smoked per day: _____

Does anyone smoke in your home? Select

Do you want to quit smoking? Select If Yes, why?

SCARS:

Do you have any scars from surgery or injuries? Select This will include episiotomy scars also.

If Yes please explain where these are located

COMPREHENSIVE INTAKE QUESTIONNAIRE

PREVIOUS ALLERGY DIAGNOSIS:

Have you ever seen an allergist? Select If yes, allergist's name: _____

Have you had allergy skin testing? Select If yes, Date: _____

Did you have any positive reactions? Select If yes, please list positive allergens (include any medications):

Have you ever received allergy injections? Select

If yes, did your symptoms improve while receiving injections? Select

Have you ever experienced an adverse reaction to an allergy injection? Select If yes, please explain:

Have you ever received Cortisone? (Prednisone, Methylprednisolone, etc.) drugs? Select

If yes, how long ago? _____ How much? _____

ENVORONMENTAL SURVEY:

Do your discomforts disturb your sleep? Select

Do you feel better when away from home? Select

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? Select Is your house built on a slab? Select

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

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

PETS:

How many of the following pets do you own? _____

Cats _____ Dogs _____ Birds _____ Other _____

Are they indoor or outdoor pets? _____ Sensitive reaction to Animals Select

SCHOOL HISTORY

Do you attend school? Select If yes, at what grade level? _____

Is your classroom: ☐ Carpeted ☐ Tile Other _____

Are there any animals in your classroom? Select

Have you missed school due to reactions or sensitivities? Select

If yes, how many days did you miss last year because of them? _____

COMPREHENSIVE INTAKE QUESTIONNAIRE

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? Select Is smoking permitted? Select
Are you exposed to chemicals or strong odors? Select If yes, briefly explain:

Do you feel worse while at work? Select If yes, briefly explain:

Have you missed time from work due to reactions or sensitivities? Select
If yes, how much time have you 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

If you had a choice what would you prefer to be Hot or Cold _____

ADDITIONAL INFORMATION

Please use the box below 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? Select If no, please explain:

Birth Weight: _____ Formula or Breast Fed? _____ Well Tolerated? _____

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

Your relationship to child: _____