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COMPREHENSIVE INTAKE QUESTIONNAIRE

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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: ____

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

If yes to any above, please explain: ____
____
____

Briefly explain any other chronic symptoms: ______________________________________
____
____
____

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

____
____

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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

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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

OTHER

THYROID

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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

I FEEL BETTER

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COMPREHENSIVE INTAKE QUESTIONNAIRE

- ☐ 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
- ☐ 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

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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? ☐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:

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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?____

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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? ____________________________

ENVORONMENTAL 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? ____________

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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? □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,

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ADDITIONAL INFORMATION

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

____

____

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____

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: ___________________________________

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