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COMPREHENSIVE/SENSITIVITY PATIENT INTAKE FORM

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:

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

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? _____

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: _____