

GOSHORN CHIROPRACTIC AND WELLNESS CENTER
NATURAL ALLERGY ELIMINATION

Name: _____ Date: _____

How were you referred?

- Physician _____
- Other _____
- Self Referral

What problem brings you or your child to this appointment? _____

What did the symptoms begin? _____

Are your symptoms getting worse? Circle: Yes or No.

Do you have any of the following symptoms? Please check all that apply.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Nasal Polyps | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Poor Sense of Smell | <input type="checkbox"/> Hives/Swelling |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Itchy Nose | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Itchy / Watery Eyes | <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Postnasal Drip | <input type="checkbox"/> Blocked Ears | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Phlegm / Sputum: Color _____ | | | <input type="checkbox"/> Other |

Which of the following trigger (or cause) the symptoms. Please check all that apply.

- | | | | |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Grass | <input type="checkbox"/> Dogs | <input type="checkbox"/> Perfumes | <input type="checkbox"/> Pollution |
| <input type="checkbox"/> Hay | <input type="checkbox"/> Horses | <input type="checkbox"/> Insecticides | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Mold & Mildew | <input type="checkbox"/> Other animals | <input type="checkbox"/> Odors | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Basements | <input type="checkbox"/> Alcoholic Beverages | <input type="checkbox"/> Drafts | <input type="checkbox"/> Cold Air |
| <input type="checkbox"/> Leaves | <input type="checkbox"/> Cosmetics | <input type="checkbox"/> House dust | <input type="checkbox"/> Humidity |
| <input type="checkbox"/> Cats | <input type="checkbox"/> Aerosol sprays | <input type="checkbox"/> Smoke | <input type="checkbox"/> Weather Changes |
| <input type="checkbox"/> Latex (rubber) | <input type="checkbox"/> Other: _____ | | |

When are your symptoms worse?

- | | | | |
|-------------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> 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 |

Are symptoms better away from home? Circle: Yes or No. If yes, when? _____

Have you been skin tested? Circle: Yes or No.

Results: _____

Have you had allergy injections? Circle: Yes or No. If yes, when? _____

Have you received drugs such as cortisone, prednisone, methyl prednisone, etc.? Circle: Yes or No.

When? _____ How much? _____

Occupation (current or previous): _____

Any harmful exposure at work or school? _____

Environmental Survey

How long have you lived in your house/apartment? _____
Approximately how old is your house/apartment/condo? _____

Do you live in a: House Apt / Duplex Condo / Town House
Do you live In the city In the suburbs Rural areas

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 use a: Humidifier Wood/Coal Stove Dehumidifier Air Cleaner

Of Pets? Indoor or Outdoor? None Cats Dogs Birds Other

Are there any tobacco smokers in your house? Yes No

Is your bedroom in the basement? Yes No

Do you have allergy proof encasing for pillow or mattress Yes No

What type of pillow do you have? _____

What type of comforter do you have? _____

What type of floor covering do you have in your bedroom? Wall to wall Area rug Animal skin Bare floor

How old is your mattress? _____ What is in your mattress? (I.e. cotton, horsehair, etc.) _____

Do you have air conditioning? Yes No If yes, Window Unit Central

Do you have problems with roaches or mice? Yes No

Do you have water leaks, mold contamination? Yes No

Is your home/apartment excessively humid? Yes No

Past Medical History

Check all that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease/hepatitis | <input type="checkbox"/> Peptic | <input type="checkbox"/> Heartburn/reflux |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart problems/murmur | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Anemia/Blood Disorder | <input type="checkbox"/> Kidney/bladder Disease | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Loss of hearing |
| <input type="checkbox"/> PMS | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Infertility | <input type="checkbox"/> Menopause |

If yes to any of the above, please explain: _____

Have you had your tonsils or adenoids removed? Yes No
Have you had ear, nose or sinus surgery? Yes No

If yes, please explain: _____

Do you smoke now? Yes No How Much? _____ # Of years? _____
Have you smoked before? Yes No When did you stop? _____ # Of years? _____

Please list any hospitalizations regardless of cause: _____

List any food allergies and reactions experienced: _____

List any drug allergies and reactions experienced (i.e. penicillin, aspirin, sulfa, latex, etc): _____

Describe any reaction to insect stings: _____

List all medications & dosages (including nasal sprays, non-allergy medications, alternative/herbal products):

Family History

Who in your family has had?

Asthma _____

Eczema _____

Seasonal or Year Round Allergies _____

Other Allergies (drugs/bees/food etc) _____

Sinus Problems _____

OFFICE USE ONLY _____

Patient Name: _____ Clinic #: _____

Date: _____ Questionnaire Reviewed: _____

Food Allergy Section:

Check any symptoms that you have experienced:

- Abdominal cramping
- Anaphylactic shock
- Arthritic type symptoms
- Canker sores
- Celiac's disease
- Constipation
- Depression
- Diarrhea or loose stools
- Difficulty concentrating
- Emotional upset
- Eczema
- Fatigue or sudden drops of energy after meals
- Gas or bloating
- Heartburn or indigestion
- Hives
- Irritable bowel syndrome (IBS)
- Irritability
- Itching – skin or rectal
- Migraine headaches
- Nausea
- Nocturnal enuresis
- Red rash around mouth, reddening or swelling of skin
- Rhinitis
- Runny nose
- Stiffness of joints
- Stomach ache
- Swelling of lips and face
- Swelling of the joints
- Vomiting
- Wheezing

Please list your 4 favorite foods:

1. _____
2. _____
3. _____
4. _____

PATIENT ACKNOWLEDGEMENT FORM

I hereby attest to the following:

- 1) I fully understand that Allergy Elimination is not a medical treatment and I am not here for medical diagnostic or treatment procedures.
- 2) The services performed by Goshorn Chiropractic are at all times restricted to consultation on the subject of nutritional matters or the sensitivities to various substances, and does not involve the use of, needles or blood tests to verify the patients sensitivities or intolerances to foods or environmental substances. All testing is done for experimental or educational purposes only and does not involve the diagnosing, prognosticating, treatment or prescribing of remedies for treatment of disease or any act which will constitute the practice of medicine.
- 3) All suggestions regarding herbs or nutritional matters are based on historical and traditional use.
- 4) The patient should **not** for any reason, ingest or expose himself/herself to any substance that he/she has previously been diagnosed as allergic or anaphylactic by a qualified physician/allergist unless he/she has first been given consent by a qualified physician/allergist.
- 5) Program compliance is required for guaranteed results.
- 6) The decision to follow any recommendations made rests solely with the undersigned.

Please Print:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Cell Phone: () _____

E-Mail Address: _____ Date of Birth: _____

Emergency Contact: _____ Phone # () _____

Signed: _____ Date: _____