J & L Balanced Living LLC

Client Intake Form

Patient Name	Today's Date
Address	Date of Birth
City, State, Zip	Phone Number
Gender: M ___ F ___ Other____	Email
Primary Care Physician	Referring Physician

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 or disease.*
- *An allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use drugs in this program.*
- *There is no single "healthy" diet that will work for everyone.*
- *Just because food is considered "healthy", does not mean it is "healthy" for you.*
- *Your diet consists of everything you* ***eat, drink, rub on your skin, or inhale****.*
- *Our procedures are safe and painless.*

Briefly describe the reason for your visit and what you hope to accomplish:

_____

_____

AGE WHEN SYMPTOMS WERE FIRST OBSERVED:

□ Infant (Age 0-2) □ Child Age (Age 3-5) □ Child (Age 6-12)
□ Adolescent (Age13-18) □ Adult (age 19-25 □ Adult (Age 26-40)
□ Adult (Age 41 and over)

PREVIOUS ALLERGY EVALUATION:

Have you ever seen an allergist? □ Yes □ No
Have you had allergy skin testing? □ Yes □ No
Did you have any positive reaction? □ Yes □ No
If yes, please list positive allergens (including any medications) below:

_____

Have you ever received allergy injections?
_____

WORK ENVIRONMENT:

What is your occupation?
_____

Are you exposed to chemicals or strong odors at work? Yes ___ No ___

If yes, briefly explain:
_____

Are your symptoms worse while at work? Yes ___ No ___

If yes, briefly explain:
_____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW?

_____

_____

_____

_____

WHEN ARE YOUR SYMPTOMS WORSE: □ Year round

□ January □ March □ May □ July □ Sept. □ November

□ February □ April □ June □ August □ October □ December

MEDICATIONS:

Do you take any of the following medications on a regular basis? (circle all that apply)

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.)

Medication that affect the immune system (Prednisone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus, etc.)

Chemotherapy

Other medications that you are currently taking: _____

SMOKING:

Do you smoke? Yes __ No __ If yes, number of cigarettes per day _____

At what age did you start? _____ Anyone smoke in your house? _____

FOOD RELATED SYMPTOMS:

□ Symptoms flare 5-60 minutes after meals
□ The smell or odor of some foods increases symptoms
□ Some foods cause swelling of the mouth or tongue
□ Some foods causes upset stomach or vomiting
□ Symptoms occur with restaurant salad bars or Asian foods
□ Symptoms occur with any regularly eaten food
□ Preservatives, additives or food coloring increases symptom
□ Some foods are craved or addictive
□ Some foods cause nasal symptoms
□ Some foods cause rashes or hives
□ Some foods cause diarrhea
□ Some foods causes headaches
□ Some foods cause asthma
□ No problem with foods

FOODS THAT CAUSES SYMPTOM(S) FROM <u>ONE HOUR TO THREE DAYS</u> AFTER EXPOSURE:

Eggs	Milk	Beef	Corn	Wheat	Soybean
Peanut	Pork	Fish	Shellfish	Orange/citrus	Potato
Tomato	Yeast	Chocolate	Coffee/Tea	None	Other

CHEMICALS THAT CAUSE SYMPTOMS:

Insecticides & pesticides	Paints &household cleaners	Perfumes & cosmetics
Gasoline & auto exhaust	Stove or furnace emissions	The smell of new fabrics or fabric store
Chemicals in the work place	Laundry detergent	Newsprint

Other _____

DID YOU SUFFER FROM ANY TYPE OF PHYSICAL, CHEMICAL OR EMOTIONAL TRAUMA JUST BEFORE YOUR SYMPTOMS WERE FIRST OBSERVED?

_____

HAVE YOUR SYMPTOMS EVER GONE AWAY FOR ANY PERIOD OF TIME? _____

PREVIOUS DIAGNOSIS OF ALLERGY?

□ Yes and allergy shots helped	□ Did not help	□ Yes medication helped	□ Did not help	□ None

FAMILY MEMBERS WITH ALLERGIC SYMPTOMS:

□ Mother	□ Father	□ Brother/Sister	□ Grandparents
□ Son/Daughter	□ Spouse	□ None	

FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS:

□ Constant/Chronic with little change	□ Present most of the time
□ Present part of the time	□ Present rarely
□ Prevents some normal activities	□ Considerable interference with normal life

□ Slight interference with normal life

□ No interference with normal life

SYMPTOMS ARE WORSE:

□ Outdoors and better indoors
□ In the bedroom or when in bed
□ During wet or damp weather
□ During known pollen seasons
□ When exposed to tobacco smoke
□ When sweeping or dusting the house
□ In air conditioning
□ Tobacco smoke bothers me more than anything else
□ At nighttime
□ During windy weather
□ When the weather changes
□ In certain rooms or buildings
□ With yard work, cut grass, leaves, hay or barns
□ In areas with mold or mildew
□ In fields or in the country

SYMPTOMS ARE BETTER:

□ After shower or bath
□ During or after physical activity
□ In air conditioning
□ After taking antihistamines
□ Indoors
□ With allergy shots

What makes you feel better?

_____

_____

ANIMAL, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE:

□ Dogs
□ Rabbits
□ Bees
□ Cats
□ Birds or Feathe
□ None
□ Horses or Cattle
□ Rodents (mice, guinea pigs, etc.)
□ Other _____

PLEASE CHECK OFF THE FOLLOWING THAT APPLY TO YOU:

Digestive Track
□ nausea & vomiting
□ diarrhea
□ constipation
□ bloated feeling
□ stomach pains or cramps
□ heart burn
□ blood and/or mucous in stools
TOTAL ____

Ears
□ itchy ears
□ ear aches/ear infections
□ drainage from ear
□ ringing in ears
□ hearing loss
□ reddening of ears
TOTAL ____

Emotions
□ mood swings
□ anxiety/fear/nervousness
□ anger/irritability/aggressive
□ argumentative
□ frustrated/cries easily
□ depression
TOTAL ____

Eyes
□ watery or itchy eyes
□ red/swollen/itchy eyelids
□ bags or dark circles under eyes
□ blurred or tunnel vision
TOTAL ____

Joints & muscles
□ pains/aches in joints
□ arthritis/osteoarthritis
□ stiffness/limited movement
□ pain/aches in muscles
□ feeling weak/tired
□ swollen/tender joints
□ growing pains in legs
□ psoriatic/gouty arthritis
TOTAL ____

Heart
□ irregular/skipped heartbeat
□ rapid/pounding heartbeat
□ chest pain
TOTAL ____

Head
□ headaches
□ faintness
□ dizziness
□ insomnia/sleep disorder
□ facial flushing
TOTAL ____

Lungs
□ chest congestion
□ asthma/bronchitis
□ shortness of breath
□ difficult breathing
□ persistent cough
□ wheezing
TOTAL ____

Mind
□ poor memory
□ difficulty completing projects
□ difficulty with mathematics
□ underachiever
□ poor/short attention
□ confusion
□ easily distracted
□ difficulty making decisions

□ learning disabilities
TOTAL ____

Mouth & Throat
□ thrush
□ chronic coughing
□ gagging/clearing throat often
□ sore throat/hoarse voice/voice loss
□ swollen/discolored tongue/lips
□ cancer sores
□ itching on roof of mouth
TOTAL ____

PLEASE CHECK OFF THE FOLLOWING THAT APPLY TO YOU (continued):

Nose
□ stuffy nose
□ chronically red/inflamed nose
□ sinus problems
□ hay fever
□ sneezing attacks
□ excessive mucous formation
TOTAL ____

Skin
□ acne
□ itching
□ hives/rash/dry skin
□ hair loss
□ flushing/hot flashes
TOTAL ____

Weight
□ binge eating/drinking
□ craving certain foods
□ excessive weight
□ compulsive eating
□ water retention
TOTAL ____

Genitourinary
□ kidney
□ frequent/urgent urination
□ bladder
□ yeast infections
□ genital or anal itch/discharge
□ yeast infections
TOTAL ____

Other conditions
□ Autism
□ A.D.H.D.
□ A.D.D.
□ Psoriasis
□ Eczema
□ Auto Immune Disorder
□ Chronic Fatigue
□ Multiple Chemical Sensitivities
□ Asthma
□ Congestive Heart Failure
□ Sever Diabetes
□ Severe Depression
□ Obsessive Compulsive Disorder
TOTAL ____