

ALLERGY QUESTIONNAIRE

CLIENT INFORMATION

Today's Date: _____ Date of Birth _____

Name: _____

Address _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone _____ Cell /Pager: _____ Age _____

Male

Female

Email address _____

Marital Status:

Married

Single

Divorced

Separated

Other

Mother's Name if minor _____ Father's Name if minor _____

Name of Individual to contact in case of emergency: _____ Phone : _____

Number of Children: _____ Names and ages of children: _____

Your Occupation: _____ Your Employer _____

Employer's Address _____ Employer's Number (____) _____

Referred to this office by: TV Screening Where?

AT&T Yellow Pages Health beat WECT WWAY Clinic Location Newspaper

Letter Health Journal Post Card Radio Flyer Attorney Phone Call

Friend - Name? _____ MD - Name? _____ Other _____

Although your history and symptoms are very important in our analysis of your condition,
it is also important for us that you understand:

- An Allergy is NOT a disease. It is nothing more than your body reacting inappropriately to what should be a harmless substance, consequently activating the body's natural defense mechanism in the form of symptoms.
- A symptom is an attempt by your body to tell you that something is wrong.
- We will be addressing the cause of your allergy.
- We do not use medications in this program.
- Our procedures are safe, painless and effective for people of all ages.

ARE YOU ALLERGIC TO ANY MEDICATIONS? NO YES WHAT KIND? _____

ARE YOU TAKING ANY MEDICATIONS? NO YES WHAT KIND? _____

ARE YOU PREGNANT? NO YES

THESE PROBLEMS ARE: RAPIDLY IMPROVING SLOWLY IMPROVING GRADUALLY
WORSENING

FLUCTUATES BUT GETTING BETTER REMAINS THE SAME RAPIDLY WORSENING

SYMPTOMS ARE WORSE IN THE Morning Afternoon Evening

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT

AGE WHEN SYMPTOMS STARTED

Infant (Age 0-3)

Adolescent (Age 13-18)

Adult (Age 26-40)

Child (Age 4-12)

Adult (Age 19-25)

Adult (Age 41+)

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

Please List Possible Foods that Cause Symptoms _____

Please List Drugs that Cause Symptoms. _____

Please List What Animals Cause Symptoms. _____

PLEASE CHECK WHICH ALLERGIC SYMPTOMS APPLY:

SYMPTOMS ARE 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
- When exposed to tobacco smoke
- Yard Work, cut grass, leaves, or hay
- Sweeping or dusting
- In Air conditioned rooms
- Don't Know

SYMPTOMS ARE BETTER:

- After shower or bath
- In air conditioned room
- Indoors
- During or after physical activity
- After taking medication
- With allergy shot
- Don't Know

NASAL SYMPTOMS:

- Itching
- Sneezing
- Runny Nose – Clear discharge

- Runny Nose – Cloudy discharge
- Worse during pollen season
- Worse with animal exposure
- Post nasal drip
- None

EAR SYMPTOMS:

- Itching
- Hearing Loss
- Blocking, Fullness, Popping
- Frequent Ear Infections
- Ear Tubes Inserted
- Ringing in Ears
- 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 most normal activities

EYE SYMPTOMS:

- Itching
- Excessive watering
- Redness
- Swelling
- Worse during pollen season
- Worse with animal exposure
- Worse with smoke or chemical exposure
- None

SKIN SYMPTOMS:

- Hives
- Rashes
- Itching
- Eczema
- Swelling
- Sores
- Once had rashes in the bends of knees & elbows

- Worse during pollen season
- Worse with animal exposure
- Skin symptoms are rare
- Skin symptoms are chronic
- None

THROAT & MOUTH SYMPTOMS:

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

CHEST SYMPTOMS:

- Tightness
- Asthma or Wheezing with Exercise
- Asthma or Wheezing around Animals
- Asthma or Wheezing during Pollen Season
- Asthma or Wheezing around Smoke
- Shortness of Breath
- Dry Coughing

- Wet Coughing
- Emphysema
- Frequent Bronchitis
- Recurring Pneumonia
- Chest Pain
- COPD
- None

BONE & JOINT SYMPTOMS:

- Bone & Joint Pain
- Redness or Swelling of Joints
- Joint Stiffness, Limited Motion
- Muscle Pain
- Muscle Weakness
- None

CHRONIC GASTROINTESTINAL SYMPTOMS

- Nausea & Vomiting
- Diarrhea
- Gas, Heartburn
- Cramps or Bloating
- Abdominal Pain
- None

Other Symptoms _____

Which Symptoms are the most bothersome? _____

PLEASE EXPLAIN WHAT YOU HAVE DONE TO TRY TO FIX THE PROBLEMS.

HAVE ALL OF THESE TREATMENTS FAILED TO FIX YOUR PROBLEM? ___ YES ___ NO

HOW HAS THIS PROBLEM AFFECTED YOUR DAILY ACTIVITIES?

PLEASE CIRCLE YOUR LEVEL OF DISCOMFORT ON THE SCALE BELOW.

NO DISCOMFORT 1 2 3 4 5 6 7 8 9 10 WORST

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

What type of care are you looking for? Temporary Relief Maximum Recovery

PATIENT HISTORY REVIEW OF SYSTEMS

0 = NEVER HAD 1 = PATIENT PRESENTLY HAS 2 = PREVIOUSLY HAD

| GENERAL | MUSCULOSKELETAL | NEUROLOGICAL |
|--------------------|------------------------|---------------------|
| Recent weight gain | Arthritis | Lightheaded/Dizzy |
| Recent weight loss | Rheumatoid Arthritis | Memory loss |
| Fatigue | Broken Bones | Headaches |
| Fever | Osteoporosis | Migraines |
| Allergies | Gout | Numbness |
| Loss of appetite | Scoliosis | Weakness |
| Chills | Spinal Trauma | Stroke |
| Cancer of Any Kind | Joint Pain (anywhere) | Tingling/Numbness |

| CARDIOVASCULAR | RESPIRATORY | INTERGUMENTARY (SKIN) |
|-----------------------|--------------------|------------------------------|
| Heart Attack | Coughing | Bruise Easily |
| Swelling of Ankles | Coughing Up Blood | Skin Rashes |
| High Blood Pressure | Chronic Cough | Discoloration |
| Low Blood Pressure | Chest Pain | Psoriasis |
| Shortness of Breath | Asthma | Changes in Moles |
| Pain Down Left Arm | Pneumonia | Sores |
| Profuse Sweating | Bronchitis | Scars |
| High Cholesterol | Tuberculosis | Itching |

| EYES, EARS, NOSE & THROAT | GASTROINTESTINAL | GENTOURINARY |
|--------------------------------------|-------------------------|---------------------|
| Blurred Vision | Gall Bladder Problems | Painful Urination |
| Double Vision | Liver Problems | Blood in Urine |
| Ear pain | Pain over Stomach | Frequent Urination |
| Hoarseness | Ulcers | Kidney Infection |
| Nose Bleeds | Colitis | Kidney Stones |
| Glaucoma | Hiatal Hernia | Incontinence |
| Dental problems | Blood in Stool | |

Other/Explanations:

Physician/Staff Signature _____

Informed Consent For Anaphylaxis

Laser Allergy Relief Centers

Anaphylaxis: Anaphylaxis is a severe life threatening allergic reaction to food, insect bites, medication or latex. It can also be exercise induced. Anaphylaxis can lead to death.

Symptoms may include but are not limited to:

Face - Itchy eyes or nose, flushed face, swelling of tongue and lips, metallic taste

Skin - Itchiness, redness, hives, swelling of skin anywhere on the body

Throat - Itchiness, tightness, hoarseness, hacking cough, difficulty swallowing, choking

Lungs - Difficulty breathing, shortness of breath, repetitive coughing, wheezing

Stomach - Vomiting, nausea, stomach pain, diarrhea

General - Dizziness, unsteadiness, drowsiness, sense of impending doom, loss of consciousness

Initials:

_____ I understand that Laser Allergy Relief Centers does not treat nor claim to treat anaphylaxis or allergies that can cause anaphylaxis and I will not hold them responsible for any anaphylactic reaction that may occur due to an allergic reaction that causes anaphylaxis.

_____ I understand that anaphylaxis can be a life threatening reaction and I understand the symptoms of an anaphylactic reaction and will in no way hold Laser Allergy Relief Centers responsible for a future anaphylactic reaction.

_____ If an Epipen has been prescribed, I agree to carry an Epipen with me at all times and will use it according to the manufacture's recommendations If I have allergic reactions that resemble anaphylaxis. I agree to keep my prescription up to date for my Epipen.

_____ I agree that if I have any of the previous symptoms of anaphylaxis described above that I will follow the following procedures.

- 1) Administer epinephrine (adrenaline) injection immediately. Give a second dose in 10-15 minutes if reaction continues or worsens.
- 2) Call 911 and tell them someone is having a life-threatening allergic reaction
- 3) Go to the hospital immediately even if symptoms subside. Remain for observation 4-6 hours

_____ I agree to stay away from drugs, insects and chemicals that I know I am allergic to especially if they have caused anaphylactic episodes in the past. Even after Laser Allergy treatments are complete I agree to always inform doctors and hospitals if I am allergic to any drugs or foods.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation Laser Allergy Relief and the related treatment. I have discussed it with the doctor and have had my questions answered to m satisfaction By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it was in my best interest to undergo the treatment recommended. Having been informed of the risks, I herby give my consent to treatment.

Patient Printed Name _____ **Date** _____

Patient Signature _____ **Tech Signature** _____

The patient had the following questions and was supplied the following answers:

It is my clinical opinion this patient is oriented to time and space: YES NO

It is my clinical opinion this patient understands the language involved: YES NO

AUTHORIZATION TO BALANCE

I, the undersigned patient, hereby authorize Becky Appelfeller to administer balancing homeopathic frequencies as is necessary, and to perform services and or procedures as are considered necessary on the basis of findings during the course of this process to get relief from their allergy symptoms.

I hereby certify that I have read and fully understand the above AUTHORIZATION TO BALANCE, the reasons why the balancing is necessary, its advantages and possible complications, if any, as well as possible alternative mode of balancing which were explained to me.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Client Signature _____ Date _____

Guardian Signature _____ Relationship _____

Witness Signature _____ Date _____