# Balanced 4 Life

## Clinic Intake Form

**Patient Name: _____** **Date: _____**
**Address: _____** **Date of Birth: _____**
**City, State, Zip: _____** **Phone #: _____**
**Gender: MALE ___ FEMALE ___** **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 underlining 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) _____
Have you ever received allergy injections? _____

**WORK ENVIRONMENT:**

What is your occupation? _____ Are you exposed to chemicals or strong odors at work? _____
If yes, briefly explain _____ Are your symptoms worse while at work? _____
If yes, briefly explain _____
ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW? _____
_____

**WHEN ARE YOUR SYMPTOMS WORSE:** ☐ Year round

☐ January ☐ February ☐ March ☐ April ☐ May ☐ June
☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

**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.)

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

Chemotherapy

Please list any medications that you are currently taking: _____
_____
_____
_____
_____
_____
_____

**SMOKING:**

Do you smoke?___ 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 symptoms
- □ 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 _____ None _____

**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 part of the time
□ Prevents some normal activities
□ Slight interference with normal life
□ Present most of the time
□ Present rarely
□ Considerable 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 □ In air conditioning □ Indoors
□ During or after physical activity □ After taking antihistamines □ With allergy shots

What makes you feel better? _____

**ANIMAL, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE:**

□ Dogs □ Cats □ Horses or Cattle
□ Rabbits □ Birds or Feathers □ Rodents (mice, guinea pigs, etc.)
□ Bees □ None □ 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/aggressiveness
- ☐ 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 ____

**Head**
- ☐ headaches
- ☐ faintness
- ☐ dizziness
- ☐ insomnia/sleep disorder
- ☐ facial flushing

TOTAL ____

**Heart**
- ☐ irregular/skipped heartbeat
- ☐ rapid/pounding heartbeat
- ☐ chest pain

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 ____

**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 ____

**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 itch/discharge/anal itching
- ☐ 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