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 CICLE 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	GENITOURINARY
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:

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____

____

____

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 _________________________ Dr. 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 Rebecca 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 __________________________