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:

_____

_____

_____

_____

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

Informed Consent to Assessments and Cold Laser Therapy

I hereby request and consent to the performance of assessments, various modes of bodywork, laser therapy, and other procedures, on me by the practitioners listed at this clinic and or anyone working at this clinic authorized by the practitioners. I have had the opportunity to discuss the nature and purpose of assessments, various modes of physical therapy, laser therapy and other procedures. I understand that results are not guaranteed.

I understand that cold laser therapy is a medical treatment that uses specific wavelengths of light to impart energy into injured cells and tissues. This energy is transformed from photon energy to biochemical energy in the cells which can then be used for balancing the energetic body. The expected direct outcomes from laser treatment may include reduced inflammation, detoxification and reduced allergen/stressor response. The indirect outcomes may include increased energy, comfort and activity levels. Alternatives to cold laser therapy include, but are not limited to traditional allergy treatments, anti-inflammatory or anti-pain medication, medical, chiropractic or naturopathic treatment.

I further understand and am informed that, as in all health care, in the practice of cold laser therapy there are some risks, including but not limited to short term aggravation of symptoms and skin irritation. When used in combination with certain medications laser therapy can cause rashes or burns and I therefore understand that I must disclose all information on my current medications to the practitioners at this clinic. Treatment over active cancer may increase the rate of tumor growth; I understand that I must disclose any history of cancer. I also understand that the laser can cause damage to the eyes when viewed directly and that laser safety eyewear, supplied by this clinic, must be worn by me during laser treatments.

I do not expect the practitioners listed at this clinic to be able to indicate or explain all risks and complications and I wish to rely on the exercise of judgment during the course of assessment and/or procedures which the practitioners feel at the time, based upon the facts known, is in my best interest.

I consent to the assessments, various modes of therapy, including but not limited to laser therapy, offered or recommended to me by the practitioners in this clinic. I intend this consent to apply to all my present and future care in this clinic.

Dated this _____ day of _____, 20_____.

Patient/Guardian Signature: _____

Name of Patient: _____

Signature of Witness: _____

Name of Witness: _____