# GOSHORN CHIROPRACTIC AND WELLNESS CENTER
## NATURAL ALLERGY ELIMINATION

Name: _____ Date: _____

How were you referred?

- ❑ Physician _____
- ❑ Other _____
- ❑ Self Referral

What problem brings you or your child to this appointment? _____

_____

_____

What did the symptoms begin? _____

Are your symptoms getting worse? Circle: Yes or No.

Do you have any of the following symptoms? Please check all that apply.

| | | | |
|---|---|---|---|
| ❑ Cough | ❑ Runny Nose | ❑ Nasal Polyps | ❑ Eczema |
| ❑ Wheezing | ❑ Nasal Congestion | ❑ Poor Sense of Smell | ❑ Hives/Swelling |
| ❑ Shortness of Breath | ❑ Itchy Nose | ❑ Ear Infections | ❑ Headaches |
| ❑ Chest tightness | ❑ Itchy / Watery Eyes | ❑ Sinus Infections | ❑ Snoring |
| ❑ Sneezing | ❑ Postnasal Drip | ❑ Blocked Ears | ❑ Fatigue |
| ❑ Phlegm / Sputum: | Color_____ | | ❑ Other |

Which of the following trigger (or cause) the symptoms. Please check all that apply.

| | | | |
|---|---|---|---|
| ❑ Grass | ❑ Dogs | ❑ Perfumes | ❑ Pollution |
| ❑ Hay | ❑ Horses | ❑ Insecticides | ❑ Exercise |
| ❑ Mold & Mildew | ❑ Other animals | ❑ Odors | ❑ Nervousness |
| ❑ Basements | ❑ Alcoholic Beverages | ❑ Drafts | ❑ Cold Air |
| ❑ Leaves | ❑ Cosmetics | ❑ House dust | ❑ Humidity |
| ❑ Cats | ❑ Aerosol sprays | ❑ Smoke | ❑ Weather Changes |
| ❑ Latex (rubber) | ❑ Other: _____ | | |

When are your symptoms worse?

| | | | |
|---|---|---|---|
| ❑ Year Round | | | |
| ❑ January | ❑ February | ❑ March | ❑ April |
| ❑ May | ❑ June | ❑ July | ❑ August |
| ❑ September | ❑ October | ❑ November | ❑ December |

Are symptoms better away from home? Circle: Yes or No. If yes, when? _____

Have you been skin tested? Circle: Yes or No.

Results: _____

Have you had allergy injections? Circle: Yes or No. If yes, when? _____

Have you received drugs such as cortisone, prednisone, methyl prednisone, etc.? Circle: Yes or No.

When? _____ How much? _____

Occupation (current or previous): _____

Any harmful exposure at work or school? _____

## Environmental Survey

How long have you lived in your house/apartment? _____
Approximately how old is your house/apartment/condo? _____

Do you live in a: ❑ House ❑ Apt / Duplex ❑ Condo / Town House
Do you live ❑ In the city ❑ In the suburbs ❑ Rural areas

Do you have a basement? ❑ Yes ❑ No
Is your house built on a slab? ❑ Yes ❑ No

Type of heating system? ❑ Hot Air ❑ Steam (radiator) ❑ Electric ❑ Hot water baseboard

Do you use a: ❑ Humidifier ❑ Wood/Coal Stove ❑ Dehumidifier ❑ Air Cleaner

# Of Pets? Indoor or Outdoor? ❑ None ❑ Cats ❑ Dogs ❑ Birds ❑ Other

Are there any tobacco smokers in your house? ❑ Yes ❑ No
Is your bedroom in the basement? ❑ Yes ❑ No
Do you have allergy proof encasing for pillow or mattress ❑ Yes ❑ No

What type of pillow do you have? _____
What type of comforter do you have? _____
What type of floor covering do you have in your bedroom? ❑ Wall to wall ❑ Area rug ❑ Animal skin ❑ Bare floor

How old is your mattress? _____ What is in your mattress? (I.e. cotton, horsehair, etc.) _____

Do you have air conditioning? ❑ Yes ❑ No If yes, ❑ Window Unit ❑ Central

Do you have problems with roaches or mice? ❑ Yes ❑ No
Do you have water leaks, mold contamination? ❑ Yes ❑ No
Is your home/apartment excessively humid? ❑ Yes ❑ No

## Past Medical History

Check all that apply:

| | | | |
|---|---|---|---|
| ❑ Diabetes | ❑ Liver disease/hepatitis | ❑ Peptic | ❑ Heartburn/reflux |
| ❑ Cancer | ❑ Heart problems/murmur | ❑ Thyroid disease | ❑ Seizures |
| ❑ High blood pressure | ❑ Osteoporosis | ❑ Arthritis | ❑ Migraines |
| ❑ Anemia/Blood Disorder | ❑ Kidney/bladder Disease | ❑ Hay fever | ❑ Depression |
| ❑ Asthma | ❑ Glaucoma | ❑ Diarrhea | ❑ Anxiety |
| ❑ Back problems | ❑ Emphysema | ❑ Cataracts | ❑ Loss of hearing |
| ❑ PMS | ❑ Endometriosis | ❑ Infertility | ❑ Menopause |

If yes to any of the above, please explain: _____

_____

_____

Have you had your tonsils or adenoids removed? ❑ Yes ❑ No
Have you had ear, nose or sinus surgery? ❑ Yes ❑ No
If yes, please explain: _____

_____

Do you smoke now? ❑ Yes ❑ No How Much? _____ # Of years? _____
Have you smoked before? ❑ Yes ❑ No When did you stop? _____ # Of years? _____

Please list any hospitalizations regardless of cause: _____

_____

_____

List any food allergies and reactions experienced: _____

_____

List any drug allergies and reactions experienced (i.e. penicillin, aspirin, sulfa, latex, etc): _____

_____

Describe any reaction to insect stings: _____

_____

List all medications & dosages (including nasal sprays, non-allergy medications, alternative/herbal products):

_____

_____

_____

## Family History

Who in your family has had?

Asthma _____

Eczema _____

Seasonal or Year Round Allergies _____

Other Allergies (drugs/bees/food etc) _____

Sinus Problems _____

OFFICE USE ONLY _____
Patient Name: _____ Clinic #: _____

Date: _____ Questionaire Reviewed: _____

**Food Allergy Section:**

Check any symptoms that you have experienced:

- ❑ Abdominal cramping
- ❑ Anaphylactic shock
- ❑ Arthritic type symptoms
- ❑ Canker sores
- ❑ Celiac's disease
- ❑ Constipation
- ❑ Depression
- ❑ Diarrhea or loose stools
- ❑ Difficulty concentrating
- ❑ Emotional upset
- ❑ Eczema
- ❑ Fatigue or sudden drops of energy after meals
- ❑ Gas or bloating
- ❑ Heartburn or indigestion
- ❑ Hives
- ❑ Irritable bowel syndrome (IBS)
- ❑ Irritability
- ❑ Itching – skin or rectal
- ❑ Migraine headaches
- ❑ Nausea
- ❑ Nocturnal enuresis
- ❑ Red rash around mouth, reddening or swelling of skin
- ❑ Rhinitis
- ❑ Runny nose
- ❑ Stiffness of joints
- ❑ Stomach ache
- ❑ Swelling of lips and face
- ❑ Swelling of the joints
- ❑ Vomiting
- ❑ Wheezing

Please list your 4 favorite foods:

1. _____
2. _____
3. _____
4. _____

# PATIENT ACKNOWLEDGEMENT FORM

I hereby attest to the following:

1) I fully understand that Allergy Elimination is not a medical treatment and I am not here for medical diagnostic or treatment procedures.

2) The services performed by Goshorn Chiropractic are at all times restricted to consultation on the subject of nutritional matters or the sensitivities to various substances, and does not involve the use of, needles or blood tests to verify the patients sensitivities or intolerances to foods or environmental substances. All testing is done for experimental or educational purposes only and does not involve the diagnosing, prognosticating, treatment or prescribing of remedies for treatment of disease or any act which will constitute the practice of medicine.

3) All suggestions regarding herbs or nutritional matters are based on historical and traditional use.

4) The patient should **not** for any reason, ingest or expose himself/herself to any substance that he/she has previously been diagnosed as allergic or anaphylactic by a qualified physician/allergist unless he/she has first been given consent by a qualified physician/allergist.

5) Program compliance is required for guaranteed results.

6) The decision to follow any recommendations made rests solely with the undersigned.

Please Print:
Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (  ) _____ Cell Phone: (  ) _____

E-Mail Address: _____ Date of Birth: _____

Emergency Contact: _____ Phone # (  ) _____

Signed: _____ Date: _____