Dr. Poane's Chiropractic Office drpoane.com

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New Patient Questionnaire For Allergy & Sensitivity Symptoms

Patient Name: _____ Gender: male / female Date: _____

Address: _____ Date of Birth: _____

Home#: _____ Work#_____

Referring Physician, Person or media that referred you to us? _____

Primary Care Physician: _____ Allergist: _____

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 diseases.*
- *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 underlying cause.*
- *We do not use drugs in this program, however nutrition or homeopathic might be recommended.*
- *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: _____

_____

Please finish this statement: "My symptoms started ever since _____"

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1. Your age now: _____ Your age when symptoms were first observed: _____

2. Did you suffer from or did you observe someone else suffering from, <u>any type</u> of physical, chemical or emotional trauma days or months before the symptoms were first observed? (auto accident, divorce (you or parent), home relocation, college) _____

3. Have your symptoms ever gone away for a period of time? _____

4. What state or country did you first notice the symptoms? _____

5. Have you ever traveled out of the country or to an island? _____

6. FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

☐ Mother ☐ Father ☐ Brother/Sister ☐ Grandparents ☐ Son/Daughter ☐ Spouse ☐ None

7. Please answer all: Do you carry an Epi pen? Yes / No

Were you ever advised to carry an Epi pen? Yes / No
Were you ever told that you had an 'anaphylactic reaction? Yes / No
Have you ever had an anaphylactic reaction? Yes / No
Has your throat ever closed or nearly closed due to an allergic reaction? Yes / No

8. If you are susceptible to an anaphylactic reaction, what will bring it on? i.e. shell fish, peanuts, etc…: _____?

9. Do you have a current medical condition, i.e. MS, epilepsy, diabetes, lupus? No / Yes

10. Are you pregnant? No / Yes

11. WHEN do the symptoms occur (circle all that apply): Daily, when I wake up, morning, afternoon, or night

12. WHEN ARE YOUR SYMPTOMS WORSE: □ Year around

□ Jan. □ Feb. □ March □ April □ May □ June □ July □ Aug. □ Sept. □ Oct. □ Nov. □ Dec.

13. WHERE DO THE SYMPTOMS EXPRESS THEMSELVES THE MOST?

Outdoors: Near home, near work, near school, friends house, relatives house, other:
Indoors: home, work, school, friends house, relatives house, other:

□ 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
□ 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

14. How long does it take you to notice the symptoms: within minutes, hours, 2-3 days? _____

15. SYMPTOMS ARE BETTER

What makes you feel better? _____

□ After shower or bath □ Indoors □ outdoors □ After taking antihistamines or medication □ With allergy shots

16. ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

□ None □ Dogs □ Cats □ Rodents (mice, guinea pigs, etc.) □ Horses or Cattle □ Rabbits □ Birds or Feathers
□ Bees □ Other _____

17. FOOD RELATED SYMPTOMS □ No problem with foods

□ Some foods are craved or addictive
□ The smell or odor of some foods increases symptoms
□ Some foods cause swelling of the mouth or tongue
□ Some foods cause 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 increase symptoms
□ Some foods cause nasal symptoms
□ Some foods cause rashes or hives
□ Some foods cause diarrhea
□ Some foods cause headaches
□ Some foods cause asthma

18. Why do you believe your symptoms are related to food?_____?

19. Do you notice symptoms when you or someone else cleans, sweeps, dusts, or vacuums? _____

20. CHEMICALS THAT CAUSE YOUR SYMPTOMS

□ None
□ Insecticides & pesticides
□ Gasoline or automobiles exhaust
□ The smell of new fabrics or fabric store
□ Laundry detergent
□ Paints & household cleaners
□ Stove or furnace emissions
□ Chemicals in the workplace
□ Other: _____

21. Do you notice the symptoms when you are around wet or damp places? _____

22. PREVIOUS ALLERGY EVALUTION

Have you ever seen an allergist? □ Yes □ No Have you ever received allergy injections? □ Yes □ No

Have you had allergy skin testing? Yes / No Have you had allergy Blood testing? Yes / No

If yes, please list positive allergens (include any medications) _____

23. WERE YOU PREVIOUSLY DIAGNOSED WITH ALLERGIES? □ NO

□ Yes and allergy shots helped □ Yes but allergy shots did not help

□ Yes and medication helped □ Yes but medication did not help

24. 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)

□ Medications that affect the immune system (Prednisone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus, etc)

□ Chemotherapy

Please list any medications not listed above that you are currently taking: _____

25. DO YOU SMOKE? NO

If yes, average number of cigarettes per day _____If yes, at what age did you start? _____

Are you around smoke in your home or work environment? □ Yes □ No

26. WORK ENVIRONMENT

What is your occupation? _____

Are you exposed to chemicals or strong odors at work? □ Yes □ No If yes, briefly explain _____

_____

Are your symptoms worse while at work? □ Yes □ No If yes, briefly explain _____

_____

27. Hobby

Do you have a hobby or hobbies? If so, what are they? _____

Does someone you live with have hobbies? Yes / no If yes, what are they? _____

Doctor's Note's:

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check **only** the ***symptom(s)*** and known ***allergen(s) and symptom triggers*** that brought you to our office today:

	Yes			Yes	
		Symptoms			***Allergens***
		Irritable Bowel (IBS)			Eggs
		Bloating			Milk / dairy / cheese
		Constipation / diarrhea			Corn
		Stomach / intestinal pains or cramps			Sugar
		Heart burn			Wheat / grains / bread
					Soy
		Reddening of ears			Fruit
		Ringing in ears			Vegetables
		Ear aches / ear infections			Chocolate
					Coffee / tea
		Sinusitis			Meat / beef / chicken / pork
		Stuffy nose / runny nose			Fish: shellfish / other fish
		Hay fever			Peanut
		Sneezing attacks			Tomato
		Excessive mucus / clearing throat			Yeast
					Wine
		Asthma			Artificial: coloring / preservatives / flavors
		Chronic cough			
		Sore throats			Pollen / trees /grass / weeds (ragweed - hay fever)
		Hoarse voice/loss voice			Flowers / plants
		Tingling lips			
					Mold / mildew / fungus
		Acne			Dust / dust mites
		Eczema / Psoriasis			
		Itching skin			Chemical sensitivities
		Hives/rash/dry skin			Cleaning products
					Personal care products: deodorant / make up, etc…
		Hot flashes			Perfume: the kind you put on your skin
		PMS/painful menstruation			Scented candles / odors / smells
		Chronic yeast infections			Toilet paper
		Watery itchy eyes			Things you touch: metal / paper / ink / latex / fabric
		Red/swollen/itchy/eyelids			
		Dark circles under eyes			Animals: cat / dog / other
					Sun
		Headache			Medication
		Dizziness			Other allergens:
		Irregular heart beat			Other conditions and symptoms:
					MS
		Mood swings			Lupus
		Depression			Autism
		Anger/fear/nervousness			Autoimmune disorder
		Fatigue			ADD / ADHD
		Other symptoms:			Obsessive compulsive disorder (OCD)