FEED YOUR BODY

Name: _____ Date: _____

D.O.B: _____

How were you referred?

❑ Physician _____

❑ Other _____

❑ Self-Referral

Do you have an anaphylactic allergy to any substance?

_____

Do you carry an EpiPen?

_____

What are 1- 3 problems bringing you to this appointment?

_____

How long have you had this issue?

_____

What are your major symptoms?

_____

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

Red rash around mouth, reddening or swelling of skin

Runny nose

Stiffness of joints

Stomach-ache

Swelling of lips and face

Swelling of the joints

Vomiting

Wheezing

Miscellaneous: Indicate any additional information about your symptoms:

_____

_____

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Are your symptoms getting worse? Circle: Yes or No

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	❑ Odours	❑ 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

Occupation (current or previous): _____

Any harmful exposure at work or school? _____

Environmental Survey

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

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

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Your 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:

_____

_____

_____

Please list any hospitalizations regardless of cause:

_____

_____

_____

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

_____

_____

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

_____

_____

_____