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Intake Questionnaire

Patient Name: _____ **Date:** _____

Parents Name (if patient is under 18**):** _____ **Date of Birth:** _____

Address: _____ **City, State, Zip:** _____

Home #:_____ **Mobile #:**_____

Email: _____ **Work #:** _____

Gender (circle one): **MALE** **FEMALE**

Referred By: _____ If you were not referred to us, how did you hear about us? _____

Primary Care Physician: _____ **Physician's Phone #:** _____

Patient herby authorizes Maximized Health to furnish a full report regarding your case history and the results of your treatments to Primary Care/ Referring Physician

_____
Signature

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.*
- *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.*
- *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: _____

_____

AGE WHEN SYMPTOMS WERE FIRST OBSERVED

- ☐ Infant (Age 0-2)
- ☐ Child (Age 3-5)
- ☐ Child (Age 6-12)
- ☐ Adolescent (Age 13-18)
- ☐ Adult (Age 19-25)
- ☐ Adult (Age 26-40)
- ☐ Adult (Age 41 and over)

Tell us about your Vaccinations:

Standard Child Vaccinations ☐ Vaccinations were not preformed
Adult Vaccinations (Please Describe) _____
Military Vaccinations (Please Describe) _____
Any other Vaccinations? _____

DID YOU SUFFER FROM ANY TYPE OF PHYSICAL, CHEMICAL OR EMOTIONAL TRAUMA JUST BEFORE YOUR SYMPTOMS WERE FIRST OBSERVED? _____

_____

_____

HAVE YOUR SYMPTOMS EVER GONE AWAY FOR ANY PERIOD OF TIME? _____

_____

_____

FAMILY MEMBERS WITH SIMILAR SYMPTOMS

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

FREQUENCY & SEVERITY OF SYMPTOMS

- ☐ Constant/Chronic with little change
- ☐ Present most of the time
- ☐ Present part of the time
- ☐ Present rarely
- ☐ Prevents some normal activities
- ☐ Considerable interference with normal life
- ☐ Slight interference with normal life
- ☐ No interference with normal life

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
- ☐ With yard work, cut grass, leaves, hay or barns
- ☐ When sweeping or dusting the house
- ☐ In areas with mold or mildew
- ☐ In air conditioning
- ☐ In fields or in the country
- ☐ Tobacco smoke bothers me more than anything else

SYMPTOMS ARE BETTER

- ☐ After shower or bath
- ☐ In air conditioning
- ☐ Indoors
- ☐ During or after physical activity
- ☐ After taking antihistamines
- ☐ With allergy shots

What makes you feel better? _____

_____

_____

ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

- ☐ Dogs
- ☐ Cats
- ☐ Rodents (mice, guinea pigs, etc.)
- ☐ Horses or Cattle
- ☐ Rabbits
- ☐ Birds or Feathers
- ☐ Bees
- ☐ Other _____

FOOD RELATED SYMPTOMS

- ☐ Symptoms flare 5-60 minutes after meals
- ☐ 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 are craved or addictive
- ☐ Some foods cause nasal symptoms
- ☐ Some foods cause rashes or hives
- ☐ Some foods cause diarrhea
- ☐ Some foods cause headaches
- ☐ Some foods cause asthma
- ☐ No problem with foods

FOODS THAT CAUSE SYMPTOMS FROM <u>ONE HOUR TO THREE DAYS</u> AFTER EXPOSURE

- ☐ Eggs
- ☐ Milk
- ☐ Beef
- ☐ Corn
- ☐ Wheat
- ☐ Soybean
- ☐ Peanut
- ☐ Pork
- ☐ Fish
- ☐ Shellfish
- ☐ Orange or other citrus
- ☐ Potato
- ☐ Tomato
- ☐ Yeast
- ☐ Chocolate
- ☐ Coffee or Tea
- ☐ Other _____
- ☐ None

CHEMICALS THAT CAUSE SYMPTOMS

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

WHEN ARE YOUR SYMPTOMS WORSE

- ☐ Year around
- ☐ January
- ☐ February
- ☐ March
- ☐ April
- ☐ May
- ☐ June
- ☐ July
- ☐ August
- ☐ September
- ☐ October
- ☐ November
- ☐ December

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 and supplements that you are currently taking:

_____

_____

_____

SMOKING

Do you presently smoke? ☐ Yes ☐ No If yes, average number of cigarettes per day _____

If yes, at what age did you start? _____

Does anyone smoke in your home? ☐ Yes ☐ No

PREVIOUS ALLERGY EVALUTION

Have you ever seen an allergist? ☐ Yes ☐ No

Have you had allergy skin testing? ☐ Yes ☐ No

Did you have any positive reaction? ☐ Yes ☐ No

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

Have you ever received allergy injections? ☐ Yes ☐ No

WORK ENVIRONMENT

What is your occupation? _____

Are you exposed to chemicals or strong odors at work? ☐ Yes ☐ No

If yes, briefly explain _____

_____

Are you symptoms worse while at work? ☐ Yes ☐ No

If yes, briefly explain _____

_____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW? _____

_____

_____

_____

_____

_____

ANYTHING ELSE YOU WOULD LIKE TO ASK? _____

_____

_____

_____

PLEASE CHECK OFF THE FOLLOWING THAT APPLY TO YOU:

Digestive Track
__nausea & vomiting
__diarrhea
__constipation
__bloated feeling
__stomach pains or cramps
__heart burn
__blood and/or mucous in stools

Ears
__itchy ears
__ear aches/ear infections
__drainage from ear
__ringing in ears
__hearing loss
__reddening of ears

Emotions
__mood swings
__anxiety/fear/nervousness
__anger/irritability/aggressiveness
__argumentative
__frustrated/cries easily
__Depression

Eyes
__watery or itchy eyes
__red/swollen/itchy eyelids
__bags or dark circles under eyes
__blurred or tunnel vision

Head
__headaches
__faintness
__dizziness
__insomnia/sleep disorder
__facial flushing

Heart
__Irregular/Skipped Heartbeat
__Rapid/Pounding Heartbeat
__Chest Pain

Joints & Muscles
__pains/aches in joints
__arthritis/osteoarthritis
__stiffness/limited movement
__pain/aches in muscles
__feeling weak/tired
__swollen/tender joints
__growing pains in legs
__Psoriatic/Gouty Arthritis
__Rheumatoid Arthritis

Lungs
__chest congestion
__bronchitis
__shortness of breath
__difficulty breathing
__persistent cough
__wheezing

Mind
__poor memory
__difficulty completing projects
__difficulty with mathematics
__underachiever
__poor/short attention span
__confusion
__easily distracted
__difficulty making decisions
__mild learning Disabilities

Mouth & Throat Thrush
__chronic coughing
__gagging/clearing throat often
__sore throat/hoarse voice/voice loss
__swollen/discolored tongue/lips
__canker sores
__itching on roof of mouth

Nose
__stuffy nose
__chronically red/inflamed nose
__sinus problems
__hay fever
__sneezing attacks
__excessive mucous formation

Skin
__acne
__itching
__hives/rash/dry skin
__hair loss
__flushing/hot flashes

Weight
__binge eating/drinking
__craving certain foods
__excessive weight
__compulsive eating
__water retention

General
__frequent illness
__frequent/urgent urination
__genital itch/discharge
__anal itching

Genitourinary
__kidney problems
__urinary tract
__bladder
__yeast infections

Other Conditions
__Autism
__A.D.H.D.
__A.D.D.
__Psoriasis
__Eczema
__Auto Immune Disorder
__Chronic Fatigue
__Multiple Chemical Sensitivities
__Asthma
__Congestive Heart Failure
__Severe Diabetic
__Severe Depression
__Obsessive Compulsive Disorder