ALLERGY QUESTIONNAIRE

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION Today's Date:_____ Date of Birth_____

Name: _____

Address_____ City_____ State_____Zip_____

Home Phone: _____ Work Phone _____ Cell: _____ Age _____

SS#_____ □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 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

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

□ 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

PA Allergy Relief at Lifeline Chiropractic, Inc.
2525 West Main Street Jeffersonville, PA 19403

AUTHORIZATION TO TREAT

I, the undersigned patient, hereby authorize Dr Stein and staff to administer such treatment as is necessary, and to perform services and or procedures as are considered necessary on the basis of findings during the course of said treatment.
I hereby certify that I have read and fully understand the above AUTHORIZATION TO TREAT, the reasons why the treatment is necessary, its advantages and possible complications, if any, as well as possible alternative mode of treatment which were explained to me.
I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Patient Signature _____ Date _____

Guardian Signature _____ Relationship _____

Witness Signature _____ Date _____