Warner Chiropractic & Allergy Relief Center

ALLERGY QUESTIONNAIRE

Patient Name: _____Date: _____

Address: _____Date of Birth: _____

City, State, Zip: _____

Home#:_____Work#:_____Cell#:_____

Gender (circle one): MALE FEMALE

E-mail address: _____

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.

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 40)

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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?

_____

_____

PREVIOUS DIAGNOSIS OF ALLERGY

□ Yes, and allergy shots helped
□ Yes, but allergy shots did not help
□ Yes, and medication helped
□ Yes, but medication did not help
□ None

FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

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

FREQUENCY & SEVERITY OF ALLERGY 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 Some Normal Activities

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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 □ Rabbits □ Bees

□ Horses or Cattle □ Birds or Feathers □ Rodents (mice, guinea pigs, etc.)

□ None □ Other_____

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FOOD RELATED SYMPTOMS

□ Symptoms flare 5 – 60 minutes after meals

□ The smell of some foods increases symptoms

□ Some foods cause swelling of mouth or tongue

□ Some foods cause upset stomach or vomiting

□ Symptoms occur with any regularly eaten food

□ Some foods cause asthma

□ Some foods cause headaches

□ Preservatives, additives or food coloring increase symptoms

□ Symptoms occur with restaurant salad bars or Asian foods

□ Some foods are craved or addictive

□ Some foods cause nasal symptoms

□ Some foods cause rashes or hives

□ Some foods cause diarrhea

□ No problem with foods

FOODS THAT CAUSE SYMPTOMS FROM ONE HOUR TO THREE DAYS AFTER EXPOSURE

□ Eggs	□ Milk	□ Beef	□ Corn	□ Wheat	□ Soybean	□ Peanut
□ Pork	□ Fish	□ Shellfish	□ Orange or other citrus		□ Potato	□ Tomato
□ Yeast	□ Chocolate	□ Coffee or Tea				

□ Other: _____

CHEMICALS THAT CAUSE SYMPTOMS

□ Insecticides & Pesticides

□ Perfumes & Cosmetics

□ Stove or Furnace Emissions

□ Chemicals in the workplace

□ Newsprint

□ Paints & Household Cleaners

□ Gasoline or Automobiles Exhaust

□ The Smell of New Fabrics or Fabric Store

□ Laundry Detergent

□ None

Other: _____

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SYMPTOMS ARE WORSE

□ January □ February □ March □ April □ May

□ June □ July □ August □ September □ October

□ November □ December □ Year Round?

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, Cytoxan, Cyclosporine, Tacrolimus, etc.)

□ Chemotherapy

Please list any medications 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

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PREVIOUS ALLERGY EVALUTION

Have you ever seen an allergist? □ Yes □ No

Have you had allergy skin testing? □ Yes □ No

Did you have any positive reactions? □ 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 your symptoms worse while at work? □ Yes □ No If yes, briefly explain:

_____

_____

_____

Is there any additional information you would like us to know?

_____

_____

_____

Is there anything you would like to ask?

_____

_____

Patient Signature:_____