LIFETIME
HEALTH AND WELLNESS

8155 W 94th Ave ●Westminster, CO 80021 ●303-423-4610 ● Fax 303-431-8658

ALLERGY PATIENT

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____ ☐ **Male** ☐ **Female** **Marital Status:** □**S** □**M** □**D** □**W**

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Telephone: _____ ☐ **Cell** ☐ **Home** **Email:** _____

Emergency Contact: _____ **Phone:** _____

Relationship to patient: _____ _____

Employer: _____ **Occupation:** _____

Who referred you?:

Name: _____ Relation: _____

Primary Care Physician (if different from above):

Name:_____ Address:_____

Phone:_____ Fax:_____

Please tell us the reason for visiting the clinic today:

_____

Date problem began: _____

Past Allergy Testing:

□No □Yes (Location and Date): _____

FOOD ALLERGY HISTORY – if you do not have food problems, please go to next page……

Are you allergic to foods?

□ No □ Yes **Mark all that apply and specify reaction (age, symptoms, last known reaction):**

□ Milk: _____

□Egg: _____

□Soy: _____

□Wheat: _____

□Peanuts: _____

□Tree nuts: _____

□Shellfish: _____

□Fish: _____

□Other foods:_____

Do you avoid or refuse certain foods? □Yes □No

Mark all that apply:

□Milk
□Egg
□Soy
□Wheat
□Peanut
□Tree nuts
□Shellfish or Fish
□Other (specify): _____

OTHER ALLERGIC PROBLEMS:

□NO □YES

Are you allergic to:

Animals? □No □Yes □Cats □ Dogs □Other: _____

Medicines? □No □Yes Specify: _____

Insect Stings? □No □Yes Specify: _____

Latex? □No □Yes Specify: _____

Do you have:

Nasal Allergies? □No □Yes When? Spring Summer Fall Winter

Eye Allergies? □No □Yes When? Spring Summer Fall Winter

Atopic Dermatitis (Eczema)? □Yes □No Have you seen a skin doctor? □ Yes □No

Frequent scratching? □Yes □No Frequent hives or swelling? □Yes □No

Have you had any of these illnesses?

		Age of Onset	Number of Times
Chicken Pox	□Yes □No		
RSV	□Yes □No		
Ear Infections	□Yes □No		
Sinus Infections	□Yes □No		
Pneumonia	□Yes □No		
Croup	□Yes □No		

Other Illnesses (specify): _____

HEALTH PROBLEMS (REVIEW OF SYSTEMS): Circle any of the problems you have had over the past few months:

*****PLEASE CHECK "None" if you have not had any problems for certain sections*****

General □ *None*

□Fatigue □Daytime Sleepiness □Trouble sleeping □Fever Chills
□Weight Loss □Poor Weight Gain □Overweight □Loss of Appetite

Eyes □ *None*

□Blurred Eyesight □Burning □Cataracts □Dry Eyes □Frequent Blinking □Watery Eyes
□Itching □Redness □Swelling

Ears, Nose, & Throat □*None*

□Snoring □Hearing Loss □Ear Pain □Nasal polyp's □Nosebleeds □Nasal Drainage
□Itchy nose □Sneezing □ Nasal/Sinus Congestion
□Dry Mouth □Post-Nasal Drip □Mouth breathing □Frequent Sore Throat
□Mouth Sores □Throat Tightness □Loss of Sense of Smell

Heart □ *None*

□Chest Pain □Dizziness □Murmurs □Fainting Spells
□Irregular Heartbeat □Palpitations

Lungs □*None*

□Cough □Cough at Night □Coughing Up Blood □Chest Tightness
□Frequent Bronchitis/Chest Colds □Wheezing □Low Oxygen Level
□Shortness of Breath During Day AND/OR Night □Shortness of Breath with Exercise

Gastrointestinal (GI) □*None*

□Frequent Belly Pain □Indigestion □Nausea □Vomiting
□Frequent Spitting Up □Heartburn □Acid Taste in Mouth
□Constipation □Diarrhea □Bloody Stool □Encopresis (bowel in briefs)
□Burping □Gassiness □Bloating □Problem Feeding □Choking on Food □Choking while Drinking
□Trouble Swallowing □Avoidance of Certain Textures: _____
□Slow Eater □Liver Problems □Yellow Skin/Jaundice □Feeling of Food Getting "Stuck"

Please List Any Medications Or Supplements	**Dose**	**Route**	**How Often**	**Taken In Past Month?**

_____ _____

Patient/Representative Signature **Date**

LIFETIME
HEALTH AND WELLNESS

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8155 W. 94th Avenue● Westminster, CO 80021● (303)423-4610 ●Fax (303)431-8658

ALLERGY CONSENT FORM

I _____ certify the doctors listed above do not claim to cure any illness or disease with NAET (Nambudripad's Allergy Elimination Techniques).

I understand that NAET is not a medical diagnostic procedure therefore does not diagnose a disease. Rather, NAET gives the practitioner an indication as to the substance(s) to which the patient may have sensitivity. NAET uses various, standard medically proven diagnostic measures and modalities (Allopathic, chiropractic, kinesiological, and acupuncture) to diagnose the patient's condition. The premise behind NAET is to desensitize a patient to a substance(s) using allopathic, chiropractic, acupuncture/acupressure, nutritional and kinesiological principles so that the patient may not experience hypersensitive symptoms when they have future contact with them.

I understand that I (my ward) am to continue all medication and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them. During the 25 hours or after if I (my ward) get a life-threatening reaction from the allergen I was treated for or from some other sources, I need to seek emergency help immediately from a physician qualified in emergency treatment, or by calling 911 or attending an emergency room at the local hospital. If I (my ward) am suffering from severe reactions to substances, I should consult an appropriate physician and take appropriate medication, such as medication to prevent itching, tissue swelling, fever, cough, pains, infection, mental irritability, violent behaviors, etc., to keep my symptoms (my ward) under control while I (my ward) am treating with NAET treatments. This way, essential NAET treatments can be completed without interruption and once I complete the essential NAET treatments for my condition, I (my ward) may not need to continue pharmaceutical drugs indefinitely.

I understand that for 25 hours after the treatment I (my ward) am to avoid eating, touching. breathing and coming within 5 feet of the substance(s) that I (my ward) have received treatment. If I (my ward) come in contact with the substance(s) for which I (my ward) am treated, I realize that the treatments may not work and I (my ward) may have a sensitivity reaction.

I understand that I (my ward) must return after my 25 hours avoidance period preferably within 24 hours but at least within 7 days, to see if I (my ward) have cleared for the substance(s). I fully understand that I (my ward) may still experience a reaction to the substance(s) of unknown severity if I (my ward) come in contact with them, if I (my ward) did not clear them completely. If I (my ward) did not clear them completely, I may require repeating of the NAET procedure until I (my ward) clear them satisfactorily.

I have read or have had read to me the above statements and have had the opportunity to ask questions about the content and by signing below I agree to the terms and procedures.

_____ _____
Patient's Signature **Date**

_____ _____
Name of the Minor **Relationship to minor (ward)**

_____ _____
Signature or Witness **Date**