Older Child/Adult Intake Form for Pacific Allergy and Wellness

For Children 7 Years and older & Adults

Name: _____ Date: _____

How were you referred?

☐ Physician ☐ Magazine Ad/ Article ☐ Brochure
☐ Website/ Online Search ☐ Health Show ☐ Other _____

What problem brings you or your child to this appointment? _____

_____

_____

When did your symptoms begin? _____

Are your symptoms getting worse? Circle: Yes or No

Do you have any of the following symptoms? Please check all that apply.

☐ Cough ☐ Runny Nose ☐ Nasal Polyps ☐ Eczema
☐ Wheezing ☐ Nasal Congestion ☐ Poor Sense of Smell ☐ Hives/ Swelling
☐ Shortness of Breath ☐ Itchy Nose ☐ Ear Infections ☐ Headaches
☐ Chest tightness ☐ Itchy/ Watery Eyes ☐ Sinus Infections ☐ Snoring
☐ Sneezing ☐ Postnasal Drip ☐ Blocked Ears ☐ Fatigue
☐ Phlegm/ Sputum: Color:_____ ☐ Other

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 ☐ Odors ☐ 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

How long have you lived in your house/apartment? _____

Approximately how old is your house/apartment? _____

Do you live in a: ☐ House ☐ Apt/ Duplex ☐ Condo/ Town House

Do you live: ☐ In the city ☐ In the suburbs ☐ Rural areas

Do you have a basement? Circle: Yes or No

Type of heating system? ☐ Hot Air ☐ Steam (Radiator) ☐ Electric ☐ Hot water baseboard

Do you use a: ☐ Humidifier ☐ Wood/Coal Stove ☐ Dehumidifier ☐ Air Cleaner

Number of Pets? _____ Indoor or Outdoor? ☐ None ☐ Cats ☐ Dogs ☐ Birds ☐ Other

Are there any tobacco smokers in your house? Yes or No

Is your bedroom in the basement? Yes or No

Do you have allergy proof encasing for pillow or mattress? Yes or No

What type of pillow do you have? _____

What type of comforter do you have? _____

Type of floor covering in your bedroom: ☐ Wall to wall ☐ Area rug ☐ Animal Skin ☐ Bare floor

How old is your mattress? _____ What is your mattress? (I.e. cotton, horsehair, etc.) _____

Do you have air conditioning? Yes or No If yes, Window Unit or Central

Do you have water leaks, mold contamination? Yes or No

Is your home/ apartment excessively humid? Yes or No

Have you had any home renovations in the past: ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months

Have you had any building envelope failure requiring major or minor repairs or moving? Yes or No

Drinking water type**:** ☐ water purifier ☐ bottled water ☐ tap water

Do you use EMF protection? ☐ Yes ☐ No ☐ Unsure ☐Want more information

Your Past Medical History

Check all that apply:

☐ Diabetes	☐ Liver disease/hepatitis	☐ Peptic Ulcer	☐ 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: _____

_____

_____

_____

Have you had your tonsils or adenoids removed? Yes or No

Have you had ear, nose or sinus surgery? Yes or No

If yes, please explain: _____

_____

_____

Were you born via Caesarean Section? Yes or No

Do you smoke now? Yes or No

Have you smoked before? Yes or No

Do you use recreational drugs? Yes or No Type_____ Frequency_____

Would you like help with smoking/ drug use: Yes or No

Family History

Who in your family has had?

Asthma: _____

Eczema: _____

Seasonal or Year Round Stressors: _____

Other Stressors (i.e. drugs/bees/food/etc): _____

Sinus Problems: _____

Please briefly list any hospitalization regardless of cause: _____

_____

_____

List any food allergies and reactions experienced: _____

_____

_____

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

_____

_____

Describe any reaction to insect stings: _____

_____

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

_____

_____

_____

_____

Food Stressor Section

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
- ☐ Nocturnal enuresis
- ☐ Red rash around mouth, reddening or swelling of skin
- ☐ Rhinitis
- ☐ Runny nose
- ☐ Stiffness of joints
- ☐ Stomach ache
- ☐ Swelling of lips and face
- ☐ Swelling of the joints
- ☐ Vomiting
- ☐ Wheezing
- ☐ Food Cravings, list foods

_____

Miscellaneous: Indicate any additional information about your symptoms:

_____

_____

_____

_____

_____

_____

_____

_____

_____