

New Life Allergy Treatment Center
"Your Natural Solution to Health"
New Patient Health History

Name _____ Ph#(home) _____ (wk) _____
Address _____ City _____ State _____
Zip Code _____ Date of Birth D/M/Y _____ Age _____ Gender _____

LIFESTYLE

Do you exercise? _____ How frequently? _____

Hobbies _____

Do you smoke? _____ If so how much? _____

Do you drink alcohol? _____ If so how much? _____

How would you rate your diet? Excelent _____ Fair _____ Poor _____ It varies _____

How would you rate your current level of stress on a scale of 0-10? _____

MEDICAL HISTORY

Do you have:

Diabetes _____

Arthritis _____

Heart Disease _____

Use a Pacemaker _____

Lung Disease _____

Mental Illness _____

Asthma _____

Cancer _____

Other (Please specify) _____

Are you currently pregnant? Yes _____ No _____

Have you ever had an Anaphylactic reaction Yes _____ No _____ If so, when was your last reaction? _____ Do you carry an epi- pen? _____ Have you ever used it? _____

Have you ever been tested for allergies before? Yes _____ No _____ How long ago? _____

Are you currently being treated for allergies (shots, medication)? _____

Do you currently take any prescription, over the counter or recreational drugs? _____

Please list _____

Are you currently taking Prednisone? _____ Other steroid medication? _____

List any vitamins or natural supplements you are currently taking _____

Have you stayed overnight in the hospital in the last three years? _____ If so, why? _____

What are your current health concerns (what brings you here today)? _____

How did you hear about NEW LIFE ALLERGY TREATMENT CENTER? _____

If you were referred by someone, please give the name _____

FEES:

Initial assessment and allergy testing.....\$90.00

Allergy treatment.....\$50.00

Patients are responsible for all fees on the day of the treatment. Forms to submit to third party insurance companies are available to you on request.

CANCELLATION POLICY:

All rescheduled or canceled appointments require 24 hours notice. You will be charged for missed appointments if 24 hours notice is not given.

I have filled out the above information to the best of my ability and believe it to be accurate. I except the terms and policies outlined above and understand my responsibilities.

Patient Signature (must be 18 to sign)

Date

Name of parent or guardian (please print)

Relationship to minor

New Life Allergy Treatment Center

PATIENT CONSENT

I (my ward) _____ understand that New Life Allergy Treatment Center does not claim to cure any illness or disease with their techniques.

I understand that the procedures used at New Life Allergy Treatment Center do not disclose disease. Rather, gives the practitioner an indication as to the substance(s) to which the patient may have energetic incompatibilities.

I understand that the most effective way to avoid symptoms caused by allergies is to avoid the allergen. Exposure to allergens has been known to cause symptoms including: asthma, cough, congestion, diarrhea, eczema, general itching, hay fever, headaches, hives, itchy watery eyes, and sinusitis, post nasal drip, shortness of breath and many others, including death.

The services offered by New Life Allergy Treatment Center are designed to test sensitivity to known allergens to assist me to determine which allergens to avoid. I understand that that there is no guarantee that all allergens to which I (my ward) may be sensitive to will be identified.

New Life Allergy Treatment Center employs various procedures that have been known to reduce sensitivity to some allergens in some cases when combined with regular professional medical care. However I understand that there is no guarantee that the procedures in my (my wards) case will be effective.

Therefore I understand that I (my ward) must do my best to avoid the allergen. I (my ward) will seek medical advice and follow my (my wards) doctors instructions at all times.

I understand that I (my ward) am advised to continue all medications and other treatment modalities as they have been prescribed by my Doctor unless otherwise advised by my Doctor.

Patient signature (must be 18 to sign)

Date

Name of parent or guardian (please print)

Relationship to minor

CANDIDA SYMPTOM ASSESSMENT QUESTIONNAIRE

A: Instructions:

Score each symptom between 0-10 depending on severity and the degree to which it applies to you; with 10 indicating a severe symptom and 0 indicating that the symptom does not apply to you.

<u>SYMPTOM</u>	<u>SCORE</u>
Aching Muscles.....	_____
Alcohol Cravings	_____
Anxiety	_____
Bread/Starch Cravings.....	_____
Bronchitis/Cough.....	_____
Chest Pain or Tightness.....	_____
Constipation.....	_____
Co-ordination Problems.....	_____
Depression.....	_____
Disorientation/Confusion	_____
Dizziness.....	_____
Ear Infections- frequent.....	_____
Emotionally over-sensitive.....	_____
Eye Tearing or Burning.....	_____
Fatigue.....	_____
Forgetfulness.....	_____
Foul Smelling Body Odor.....	_____
Foul Smelling Breath.....	_____
Frequent Colds and Flues.....	_____
Frequent Bladder or Prostate infections.....	_____
Headaches.....	_____
Heartburn.....	_____
Hives.....	_____
Hunger causes shakes or irritability.....	_____
Infertility or Endometriosis.....	_____
Intestinal Discomfort/Pain.....	_____
Intolerant to mold.....	_____
Irritability/Jumpiness.....	_____
Itchy Rectum.....	_____
Itchy Ears/Nose.....	_____
Joint Pain.....	_____
Loose Stools.....	_____

- Menstrual Irregularities..... _____
- Mood Swings..... _____
- Mucus in Stools..... _____
- Food Intolerances..... _____
- Nasal or Sinus Congestion..... _____
- Numbness/Tingling or Burning Sensations..... _____
- Oral Thrush..... _____
- Panic Attacks..... _____
- Perfume/Chemical Sensitivities..... _____
- Poor Balance..... _____
- Poor Concentration..... _____
- Post Nasal Drip..... _____
- Psoriasis/Eczema/Skin Rashes..... _____
- Sleep Disturbances..... _____
- Sore Throat (frequent)..... _____
- Spots in Front of Eyes..... _____
- Sugar Cravings..... _____
- Tobacco Smoke Intolerance..... _____
- Vaginal Yeast Infections..... _____
- Weak Digestion/Gas/Bloating..... _____
- Weakness/Trembling..... _____
- White Coating on Tongue..... _____

A. TOTAL: _____

B. Score 5 points for each of the following questions that applies to you.

- More than one pregnancy..... _____
- Use of birth control pills for more than six months..... _____
- Antibiotics for more than three weeks..... _____
- Four or more short antibiotic treatments in a two year period..... _____
- Use of any steroid drug for four weeks or more in the last five years..... _____

B. TOTAL: _____

TOTAL SCORE A & B: _____

Mild-35 to 55

Moderate-55 to 85

Severe- 85 and higher

This questionnaire is not a definite diagnosis of Candida, as other conditions may produce similar symptoms. but gives your practitioner an indication as to whether or not Candida is a possibility and make appropriate recommendations.