ADVANCED
ALLERGY RELIEF & WELLNESS CENTER

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www.BecomeAllergyFree.com

NEW PATIENT FORM

Patient Name: _____ **Date:** _____ **Height:** _____ **Wt:**_____

If Minor, Parents Names:_____ **Date of Birth:** _____ **Age:**_____

Address: _____ **Home#:** _____

City, State, Zip: _____ **Cell#:**_____

Gender (circle one): **MALE** **FEMALE** **Work#:** _____

Referred by: _____ **Email:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Spouses Name:**_____

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, an autoimmune response.*
- *A symptom is an attempt by your body to tell you something is wrong.*
- *We will attempt to find the underlying causes of your health issues by addressing the 6 steps of wellness.*
- *We do not use needles, drugs, or avoidance in this program.*
- *There is no single "healthy" diet that will work best for everyone.*
- *Just because food is considered "healthy", does not mean it is "healthy" for you.*
- *Your diet consists of everything you **eat, drink, breathe, or rub on your skin**.*
- *Our procedures are safe and painless.*
- *Our bodies are like snow flakes...No two are alike!*
- *We need to not just address symptoms, but the underlying causes so you can get and stay healthy!*
- *I, nor any other doctor, has a Crystal Ball thus many things can change on us and what we need to do*
- ***DO WHAT YOU DID, GET WHAT YOU GOT!***

Briefly describe the reason for your visit and what you hope to accomplish: _____

_____

MAIN COMPLAINTS:

1)_____ 2)_____ 3)_____

HOW LONG HAVE YOU SUFFERED WITH THIS/THESE PROBLEMS?

1)_____ 2)_____ 3)_____

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? _____

Patient Name:_____ **Advanced Allergy Relief & Wellness Center**

WEIGHT LOSS PATIENTS ONLY:

1) How much weight would you like to lose? _____

2) Would you be willing to make some lifestyle changes to achieve this weight loss goal?

Yes _____ No _____(Please explain) _____

_____

3) What diets or systems have you tried in the past? _____

_____

4) What was the result? _____

_____

5) Do you have any of the following illnesses or symptoms? Answer "yes" or "no."

Diabetes_____	Allergies _____	Irregular menstrual cycle _____
Digestive problems. _____	Low blood sugar_____	Often crave junk food/sweets?_____
High bld. pressure ____	Low blood pressure _____	
Low energy _____	Skin eruptions_____	

6) Do you exercise? If so please state what you do _____

_____

7) How often? _____

8) What do you dislike the most about being overweight? _____

_____

_____

9) What health difficulties are you experiencing that you feel may be a result of being overweight?

_____

_____

10) Please give an example of a typical day's meals/snacks:_____

_____

_____

_____

11) Please write down three reasons you would like to lose weight. These shouldn't be generalizations, but rather personal reasons that actually mean something to you. It is important to list these out as both a guide for us to help you, and motivation for yourself so that you may reach your ideal weight.

_____

_____

_____

_____

THYROID PATIENTS ONLY:

1) How long did you have symptoms prior to being diagnosed?_____

2) If on thyroid medication, how long have you been on them?_____

3) Has your medications been adjusted frequently?_____

4) Do you have symptoms of brain fog or memory difficulties? _____

5) Do you have joint inflammation? _____

6) Do you consume grains? Y / N **If so, how many times a day?**_____

7) Heart Palpitations? _____

8) Hot Flashes or Sweat Attacks? _____

9**) Have you been diagnosed with an autoimmune condition?** _____

Patient Name:_____ **Advanced Allergy Relief & Wellness Center**

PREVIOUS DIAGNOSIS OF ALLERGY

□ Yes and allergy shots helped □ Yes but allergy shots did not help □ Yes, but no treatments
□ 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
□ Prevents some normal activities □ Considerable interference with normal life
□ Slight interference with normal life □ No interference with normal life

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

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 □ Rodents (mice, guinea pigs, etc.)
□ Horses or Cattle □ Rabbits □ Birds or Feathers
□ Bees □ Other _____
□ None

FOOD RELATED SYMPTOMS

□ Symptoms flare 5-60 minutes after meals □ Some foods are craved or addictive
□ The smell or odor of some foods increases symptoms □ Some foods cause nasal symptoms
□ Some foods cause swelling of the mouth or tongue □ Some foods cause rashes or hives
□ Some foods cause upset stomach or vomiting □ Some foods cause diarrhea
□ Symptoms occur with restaurant salad bars or Asian foods □ Some foods cause headaches
□ Symptoms occur with any regularly eaten food □ Some foods cause asthma
□ Preservatives, additives or food coloring increase symptoms □ No problem with foods

Patient Name:_____ **Advanced Allergy Relief & Wellness Center**

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
- ☐ None
- ☐ Other _____

CHEMICALS THAT CAUSE SYMPTOMS

- ☐ Insecticides & pesticides
- ☐ Paints & household cleaners
- ☐ Perfumes & cosmetics
- ☐ Gasoline or automobiles exhaust
- ☐ Stove or furnace emissions
- ☐ The smell of new fabrics or fabric store
- ☐ Chemicals in the workplace
- ☐ Laundry detergent
- ☐ Newsprint
- ☐ Other: _____

WHEN ARE YOUR SYMPTOMS WORSE

- ☐ Year around
- ☐ January
- ☐ February
- ☐ March
- ☐ April
- ☐ May
- ☐ June
- ☐ July
- ☐ August
- ☐ September
- ☐ October
- ☐ November
- ☐ December

HOW HAVE YOU TAKEN CARE OF YOUR HEALTH IN THE PAST?

Medications___ Holistic___ Vitamins___ Exercise___ Diet & Nutrition___
Routine Medical___ Chiropractic___ Naturopathic___ Other_____

HOW DID ANY OF THESE PREVIOUS METHODS WORK FOR YOU?_____
_____
_____
_____

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, Cyclosporine, Tacrolimus, etc)

Please list any MEDICATIONS that you are currently taking:

1)_____ Condition:_____

2)_____ Condition:_____

3)_____ Condition:_____

4)_____ Condition:_____

5)_____ Condition:_____

6)_____ Condition:_____

Patient Name:_____ **Advanced Allergy Relief & Wellness Center**

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

PREVIOUS ALLERGY EVALUTION

Have you ever seen an allergist? □ Yes □ No

Have you had allergy skin testing? □ Yes □ No

Did you have any positive reaction? □ 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 you symptoms worse while at work? □ Yes □ No

If yes, briefly explain _____

_____

WOULD YOU LIKE IMPROVEMENT WITH ANY OF THE FOLLOWING?

□ Digestion: Reflux, Gas, Constipation □ Sleep: Falling or Staying Asleep

□ Sense of Well Being □ Energy

WHAT HAVE YOU TRIED DOING TO RESOLVE THIS PROBLEM THAT <u>DID NOT</u> WORK?

_____

_____

HAVE YOU BECOME DISCOURAGED OR STRESSED ABOUT HANDLING THIS PROBLEM?

_____

_____

WHEN YOUR PROBLEM IS AT ITS WORST, HOW DOES IT MAKE YOU FEEL?

_____

_____

HOW DOES THIS PROBLEM INTERFERE WITH THE FOLLOWING AREAS IN YOUR LIFE?

Work:_____ Family:_____

Hobbies:_____ Life:_____

WHEN IT'S AT IT'S WORST, HOW MUCH OLDER DOES THIS MAKE YOU FEEL?_____

Patient Name:_____ **Advanced Allergy Relief & Wellness Center**

ARE YOU HERE VISITING US TO:

A) Resolve immediate symptoms B) Life Style Program for addressing the core problems/causes

C) Both D) Other:_____

WHAT AREAS ARE YOU AFRAID MIGHT BE NEGATIVELY AFFECTED WITHOUT A CHANGE?

Job___ Kids___ Marriage___ Sleep___
Freedom___ Activities___ Finances___ Time___

ARE THERE ANY HEALTH CONDITIONS YOU ARE AFRAID THIS MIGHT TURN INTO?

Thyroid Disorders___ Surgery___ Stress___ Weight Gain___ Depression___ Diabetes___
Heart Disease___ Arthritis___ Cancer___ Other_____

WHERE DO YOU PICTURE YOURSELF BEING IN THE NEXT 3-5 YEARS IF THIS PROBLEM IS NOT TAKEN CARE OF? PLEASE BE SPECIFIC_____
_____
_____

WHAT WOULD BE DIFFERENT OR BETTER WITHOUT THIS PROBLEM?

Less Stress___ Sleep___ Energy___ Self Esteem___ Confidence___ Family___ Outlook___

IF WE WERE TO SIT DOWN AND DISCUSS YOUR LIFE 3 YEARS FROM NOW AND LOOK BACK TODAY, WHAT WOULD HAVE TO HAVE HAPPENED FOR YOU TO BE HAPPY WITH YOUR PROGRESS? (Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

_____
_____
_____
_____
_____

WHAT POTENTIAL BARRIERS DO YOU FORSEE THAT WOULD PREVENT THESE THINGS FROM HAPPENING? _____
_____
_____

DO YOU FEEL IT IS POSSIBLE TO ELIMINATE OR PREVENT THESE POTENTIAL BARRIERS?

_____
_____
_____

WHAT ARE YOUR STRENGTHS THAT WILL ENABLE YOU TO ACCOMPLISH YOUR GOALS?

_____
_____

Patient Name:_____ **Advanced Allergy Relief & Wellness Center**

RATE ON A SCALE OF 1-10:

____HOW IMPORTANT IS IT FOR YOU TO RESOLVE YOUR HEALTH CONCERNS?
____DO YOU FEEL YOU ARE COACHABLE & WOULD ENJOY A MENTOR/ COACH IN HELPING YOU?
____ARE YOU PREPARED TO MAKE THE APPROPRIATE LIFESTYLE CHANGES THAT MAY BE NECESSARY IN ORDER TO ACHIEVE YOUR GOALS?

LIFESTYLE

What percentage of your DAILY diet includes ORGANIC FOODS? _____%
How many ounces of WATER do you drink each DAY? _____oz per day
How many cups of COFFEE, ENERGY DRINKS or SODA do you drink?_____cups per week or day
How often do you perform INTENSE EXERCISE of 30 minutes or more? _____ per week or month
Is there a big difference between typical store bought synthetic vitamins vs whole food vitamins? □Yes □No □ Maybe
Please list any VITAMIN, MINERAL or HERBAL SUPPLEMENTS that you are currently taking:

_____
_____
_____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW? _____
_____
_____
_____

ANYTHING ELSE YOU WOULD LIKE TO ASK? _____
_____
_____
_____

THAN YOU VERY MUCH *FOR SPENDING THE TIME TO FILL OUT THIS EXTREMELY DETAILED FORM!*
THIS REALLY HELPS US KNOW WHERE YOU ARE AND WHERE WE NEED TO GET YOU
SO WE CAN HELP YOU MAXIMIZE YOUR RESULTS AS A MEMBER HERE WITH US

The 10 Objections to Creating a Healthy, Abundant Life:

1. **I don't have the personal knowledge to make the correct lifestyle choices.**
   a. You have the power to choose to learn. If you are open to learning, our personal mentoring program will guide you along an easy to follow path. Our programs our structured in a manner that gives each and every patient the information needed to bring independence to their life. You do have the choice to avoid the all too common dependency of a care-giver or assisted living environment.

2. **I don't have the time to take appropriate care of myself.**
   a. We all live in a world that gives each of us 24 hours /day. What we do with that time is a personal decision based on values (real or perceived). If you do not take time to care for yourself, you will have to take time to try and repair yourself. Pro-activity and maintenance are required for optimized health. It takes no more time to eat correctly than poorly. Proper exercise requires no more than approximately 35 minutes 3-4 times / week. If you're honest with yourself, you recognize it really is based on what you judge as a valuable use of your time. Hum? TV, or a thriving, abundant life.

3. **My family won't be on board with the changes I will need to make.**
   a. I recognize this sounds like a silly thought, but also realize it is a real concern for some. You would certainly think that all family members would be on board, however, in infrequent situations a spouse or family member may be negative toward your new enthusiasm. This usually comes down to a lack of understanding of what your lifestyle program entails, as well as some distrust of whether this approach will really work.
   It may help to steer these family members to our site, www.BecomeAllergyFree.com, and view some of the incredible testimonials from our patients. Without taking the time to learn about our programs and proven success it is only human nature to be cautious. Once familiarizing themselves, you will not only get support, but an accountability partner to help ensure your success.

4. **Eating right is too hard and expensive.**
   a. If you have not been eating right, you should already understand how expensive eating wrong can be. Health deteriorates and medical bills escalate with each year that these poor choices are made. Like any habits, there are good and bad. Once you develop a habit it can be a challenge to change or alter. Once the good or correct habit is developed it will be hard to break. I would challenge anyone to compare grocery bills of a cart full of healthy food compared to one full of junk. And speaking of expense, this is not just a financial term. Losing out on the joys and experience in life because your not feeding your body nutritious foods is a terrible, unnecessary expense.

5. **I can't afford a lifestyle program or hire a health coach.**
    a. Most people recognize the importance of an education, whether this is a high-school, college or even an online education. It's widely accepted that this is an investment that must be made in order to have the best insurance of meeting our financial needs. The return on this financial investment can materialize into a very secure and abundant life.
    Although there are situations in life where funding higher education can seem impossible, we witness people everyday finding solutions to "get it done". These individuals simply think differently. They do not accept anything less than their God given potential. I am suggesting that your health should be viewed as at least as valuable as your financial situation. What value is wealth if you do not have the health and vitality to enjoy it. At Advanced Allergy and Wellness Center, we work with each individual to overcome any financial obstacles. We have solutions to allow those on fixed budgets and retired to easily move forward.

6. **I'm afraid that proper lifestyle changes might isolate me from my friends and family.**
    a. It is true that not all of your friends will share your newly found optimism toward taking control of your health. Friends who do not place high priority on their health often play down healthy lifestyle choices. Although they may not mean any negative intent, this behavior is sabotaging. The bottom line is those who truly care for you will support your decision to place your health as a priority.

7. **My doctor may not approve.**
    a. I will always be open and willing to work with any doctor or health professional you currently have. They also, should be open and willing to do the same if the goal is to optimize health and improve lifestyle choices. This includes reducing and/or eliminating unnecessary medications. A doctor's main concern and intent should always be to aid in the optimization of health in his/her patients. This begins with "Do No Harm". I am always cautious of a physician that dismisses any holistic and natural approach to health. In summary, you are ultimately responsible for your health and therefore, the final decision and direction you wish to pursue.

8. **I don't have the self discipline to make permanent changes.**
    a. Self discipline is not a trait that we are born with, but one that is developed over time through life experience. Discipline coincides with positive experience. In other words, as your actions result in positive changes you will be inclined to continue these actions. One could look at this as positive habits or simply, discipline. Self discipline is also strengthened thru accountability held by loved ones, a friend or a mentor.

9. **What happens if I commit to a lifestyle program and then hate the experience and give up?**
    a. Life is a series of ups and downs. We do not always enjoy the duties required for the end result we are seeking. It's funny how these duties or actions can initially seem to be difficult or "no fun", but later take on an uplifting emotion. This is because we come to recognize the most meaningful successes we have in life came from such actions. Having a successful marriage; raising children; optimizing our health and becoming financial independent all require discipline and actions that sometimes have us wanting to "give up and quit". Those of us who continue to play the game are allowed the pleasures of earned rewards.

10. **I don't have the personal confidence to take action.**
    a. Very few of us have a natural born instinct of confidence. This comes from continually taking action even when we are fearful. The actual definition for this is courage. As we continue to develop skills from taking these bold steps, we become less fearful or confident. My son, Tucker, has always lacked confidence as he enters a new sport. He is often hesitant to even giving it a try. Once he jumps in, regardless of the fear, he begins to develop skills that ultimately lead to enjoyment and yes, confidence! We are here to mentor you and support you. We do not judge or chastise. We offer an environment that anyone at any level can feel comfortable and genuinely cared for. As you become a veteran in the art of wellness, you too will become very confident.