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Please note: AAT does not diagnose specific allergies. We locate possible reactions to various substances like foods, airborne inhalants, external contactants and other stimuli that may be causing your body to react inappropriately. This is usually due to the body reacting to a harmless substance *in error*. AAT treatment is aimed at correcting this error. We do not treat or diagnose any specific disease or condition.

NAME:_____ **DATE:**_____
Address: _____City: _____ State: _____ Zip: _____
Phone: (H) _____ (W) _____ (C) _____
Email Address: _____
Date of Birth: ____/_____/_____ Age: _____ Occupation: _____
Marital Status: _____ Emergency Contact: _____
How Did You Hear About Our Clinic? _____

What would you like to accomplish during your visit at the Clinic?
_____

SECTIONS: Please Select The Section or Sections that Apply to You and Complete Those Sections Only:

1. **Respiratory** (Nasal / Throat, Sinuses, Mouth, Chest, Eyes)
2. **Food Intolerance** (Dairy, Wheat, Corn, Veggies, Fruits, etc)
3. **Gastrointestinal** (Indigestion, Stomach Pain, Gas, Bloating, Cramps, Constipation, Diarrhea)
4. **Skin** (Rash, Eczema, Itch, Psoriasis, Redness)
5. **Contact Reactions** (Soap, Lotion, Fabrics, Chemicals, Perfumes, etc)
6. **Stimuli** (Sunlight, Cold, Heat, Weather Changes)
7. **Fatigue/Stress**

SECTION 1: RESPIRATORY

NASAL/THROAT

- ☐ Mucous dripping down the back of your throat (Post-Nasal Drip)
- ☐ Congestion / Stuffiness
- ☐ Sneezing
- ☐ Itchy nose / Itchy throat
- ☐ Nosebleeds
- ☐ Runny nose - what color mucous? _____

SINUSES

- ☐ Pain/Pressure
- ☐ Frontal Headache
- ☐ Congestion / Fullness
- ☐ Popping

MOUTH: Itch ___ Burn ___ Cold Sores ___

CHEST

- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough with exercise
- ☐ Cough with laughter
- ☐ Coughing at night or when you lay down

EYES

- ☐ Watering/tearing
- ☐ Itching
- ☐ Redness
- ☐ Swelling

SECTION 2: FOOD INTOLERANCE
Foods You Suspect or Have Been Tested For:

- ☐ Dairy: _____
- ☐ Grains: _____
- ☐ Corn
- ☐ Sugar
- ☐ Eggs
- ☐ Meats: _____
- ☐ MSG ____ Sulfites ____ Wines ____ Vinegar ____ Acid Foods ____ Spicy Foods ____ Shellfish_____
- ☐ Veggies: _____ Fruits: _____
- ☐ Coffee ____ Caffeine ____ Tea ____ Soft Drinks ____ Chocolate ____ Artificial Colors ____
- ☐ Other: _____

SECTION 3: GASTROINTESTINAL **Details:**

- ☐ Stomach Pain _____
- ☐ Indigestion _____
- ☐ Reflux _____
- ☐ Heartburn _____
- ☐ Diarrhea _____
- ☐ Constipation _____
- ☐ Gas / Bloating _____

SECTION 4: SKIN **Details:**

- ☐ Itching _____
- ☐ Swelling _____
- ☐ Rashes _____
- ☐ Hives/Welts _____
- ☐ Dry skin _____
- ☐ Have you had a diagnosis of: Eczema ___ Psoriasis ___ Contact Dermatitis ____
- ☐ Other: _____

SECTION 5: CONTACT REACTIONS **Details:**

- ☐ Soaps _____
- ☐ Lotions _____
- ☐ Fabrics _____
- ☐ Chemicals _____
- ☐ Perfumes _____
- ☐ Other: _____

SECTION 6: STIMULI **Details:**

- ☐ Sunlight _____
- ☐ Cold _____
- ☐ Heat _____
- ☐ Weather Changes _____
- ☐ Humidity _____
- ☐ Motion Sickness _____
- ☐ Air Conditioning _____
- ☐ Other: _____

SECTION 7: FATIGUE / STRESS

- ☐ Do you have chronic fatigue / tiredness? Yes ___ No ___
- ☐ Do you think you ever have "Low Blood Sugar"? Yes ___ No
- ☐ Do you have chronic 'Stress'? ( ) Severe ( ) Moderate ( ) Mild
- ☐ Have you ever been told you have "Adrenal Exhaustion" ? Yes___
- ☐ Have you ever been told you have "Low Thyroid" ? Yes ___
- ☐ Other: _____

Which of the above symptoms bother you <u>the most</u> (Your Top Priorities**?**)

_____

SYMPTOM PROGRESSION:

- ☐ My symptoms have been unchanged for some time.
- ☐ My symptoms have been getting worse over the past few:
  - ☐ weeks
  - ☐ months
  - ☐ year

My symptoms are worse during ;

- ☐ spring
- ☐ summer
- ☐ fall
- ☐ winter

- ☐ My symptoms are **present all throughout the year, but they flare-up during** _____

PROVOKING FACTORS:

Do any of these things seem to bring on or aggravate your symptoms?

- ☐ Trees/Pollens
- ☐ Dust/Molds
- ☐ Dog/Cat/Other animals
- ☐ Tobacco smoke
- ☐ Weather changes
- ☐ Cold air/Air conditioning
- ☐ Chemicals/Perfumes
- ☐ Exercise or Physical exertion
- ☐ Laughter
- ☐ Foods? Which ones?_____

ALLERGY HISTORY:

Have you been treated for allergies in the past?

- ☐ No
- ☐ Yes

Did you see an allergist? ☐ **NO** ☐ **YES** Doctor?_____

What kind of testing was done? Where? _____

- ☐ Skin testing
- ☐ Blood testing (RAST)

When was testing done?_____

What were the results?_____

_____

What type of treatment was recommended?_____

_____

If you were placed on allergy shots, how long were you on them?_____

Did they help with your allergies? ☐ **NO** ☐ **YES**

Did you have any significant reactions to your allergy shots? ☐ **NO** ☐ **YES, please explain**:_____

_____

MEDICATION HISTORY:

Please list **prescription** allergy medications you are **currently taking**. Please include all pills, eye drops, nasal sprays and lung sprays.

MEDICATION	**DOSE**	**HOW OFTEN**	**DOES IT HELP?**	**SIDE EFFECTS**

Please list **over-the-counter** allergy medications / Herbs (non-prescription) you are currently taking.

MEDICATION	**DOSE**	**HOW OFTEN**	**DOES IT HELP?**	**SIDE EFFECTS**

Please list any other medications you have taken in the past (those not listed above)

_____

_____

GENERAL MEDICAL HISTORY:

Who is your primary doctor or family physician? _____ City:_____

Are you allergic to any medications?

- ☐ No
- ☐ Yes; I am allergic to:_____

What type of reaction did you have?_____

Have **you** been diagnosed with any of the following medical conditions?

ASTHMA	☐ No	☐ Yes
HIGH BLOOD PRESSURE	☐ No	☐ Yes
ELEVATED CHOLESTEROL	☐ No	☐ Yes
GASTROESOPHAGEAL REFLUX (GERD)	☐ No	☐ Yes
DIABETES	☐ No	☐ Yes
LIVER DISEASE/HEPATITIS	☐ No	☐ Yes
SEXUALLY TRANSMITTED DISEASE	☐ No	☐ Yes
GLAUCOMA	☐ No	☐ Yes

OTHER:_____

SMOKING HISTORY:

☐ I have never smoked.
☐ I stopped smoking _____ years ago. I used to smoke _____ pack(s) a day for _____years.
☐ I am a smoker now and smoke about _____pack(s) per day.
☐ I do not smoke but I am frequently exposed to second hand smoke at _____.

SURGICAL HISTORY:

☐ I have not had any surgeries.
☐ Yes, I have had:
- ☐ Tonsils Date:_____
- ☐ Adenoids Date:_____
- ☐ Nasal/Sinus surgery Date: _____ Surgeon:_____
- ☐ Other Surgery:_____ Date:_____

Were there any complications associated with your surgery, including the anesthesia used?
- ☐ No
- ☐ Yes; please explain._____

IMAGING STUDIES (XRAYS):

☐ None
☐ Sinuses Date: _____ Results:_____
☐ Chest Date: _____ Results:_____
☐ Other _____ Date:_____ Results:_____

FAMILY HISTORY:

Does anyone in your family have any of these conditions?
- ☐ Hayfever Who?_____
- ☐ Sinus problems Who?_____
- ☐ Skin rashes/facial or lip swelling Who?_____
- ☐ Asthma Who?_____
- ☐ No one in my family has allergies.

MATERNAL (Mother) HISTORY:

☐ Living AGE:_____ Any medical problems? ☐ No ☐ Yes; _____
☐ Deceased at age:_____ Cause of death:_____

PATERNAL (Father) HISTORY:

☐ Living AGE:_____ Any medical problems? ☐ No ☐ Yes;_____
☐ Deceased at age:_____ Cause of death:_____

Do you have any children? ☐ No ☐ Yes.
Do they have any medical or Allergy problems? ☐ No ☐ Yes: _____
_____
Would you like to discuss your children's health concerns with the doctor? _____
_____

ENVIRONMENTAL HISTORY:

Do you live in a:

☐ House
☐ Apartment
☐ Townhouse/Condo/Duplex

Have you EVER had **Mold** in your house? Basement? ___ Bathroom? ___ Windows? ___ Attic? ____

Does anyone in the house smoke? ☐ No ☐ Yes
Is there smoking in the bedroom ☐ No ☐ Yes

Do you have any **pets?** ☐ No ☐ Yes, I have: _____
Are they allowed to come in the bedroom? ☐ No ☐ Yes
Are they bathed? ☐ No ☐ Yes

What type of heating do you have in the house?

☐ Central furnace with forced-air heating
☐ Wall heaters
☐ Radiant-heating system
How old is the system?_____ years old.
☐ The heating system is new.

Has the system been professionally cleaned?

☐ Yes, how long ago?_____
☐ Not since I've lived in the house.
☐ I don't know.

Are there special allergy filters in the heating system? ☐ No ☐ Yes
Do you have air-conditioning? ☐ No ☐ Yes

BEDROOM

Do you have carpeting in the bedroom? ☐ No ☐ Yes
I have _____floors in the bedroom.

Do you sleep on any type of feather bedding?

☐ No
☐ Yes ☐ Pillow ☐ Down comforter ☐ Feather bed

Do you sleep on a waterbed? ☐ No ☐ Yes
Do you have an air-purifier in the bedroom? ☐ No ☐ Yes, it runs _____hours a day.

LIFESTYLE:

Have your allergies affected your work, relationships or your recreational activities?

☐ No
☐ Yes, please explain._____
_____

ADDITIONAL COMMENTS:

Please use this space to expand on any issues you would like us to be aware of:

_____
_____

Patient Signature: _____ Date: _____

****If Patient is a Minor Child, Parent or Guardian Please Sign to Authorize Care/Treatment of Minor****
Name of Minor Child: _____ Age: _____
Parent Signature to Authorize Care: _____ Date: _____

FOR OFFICE USE ONLY
AirB: ____ Food: ____ GI: ____ Skin: ____ Cont: ____ Stim: ____ Fatigue: ____ Endocrine: ____