adults . children . pregnancy

CRAM

CHIROPRACTIC and WELLNESS CENTER

ALLERGY QUESTIONAIRE

Patient Name: _____ **Date:** _____
Address: _____ **Date of Birth:** _____
City, State, Zip: _____ **Home#:**_____
Gender (check one): ____ **MALE** ____ **FEMALE** **Work#:**_____
Primary Care Physician: _____ **Referring Physician:** _____

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.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use drugs in this program.*
- *There is no single "healthy" diet that will work for everyone.*
- *Just because food is considered "healthy", does not mean it is "healthy" for you.*
- *Your diet consists of everything you **eat, drink, rub on your skin**, or **inhale**.*
- *Our procedures are safe and painless.*

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

AGE WHEN SYMPTOMS WERE FIRST OBSERVED

☐ Infant (Age 0 -2) ☐ Child (Age 3 – 5)
☐ Child (Age 6 – 12) ☐ Adolescent (Age 13 – 18)
☐ Adult (Age 19 – 25) ☐ Adult (Age 26 – 40)
☐ Adult (Age 40)

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? _____

PREVIOUS DIAGNOSIS OF ALLERGY

☐ Yes, and allergy shots helped. ☐ Yes, but allergy shots did not help
☐ 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

Over ➔➔➔

FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS

- ☐ Constant, Chronic with Little Change
- ☐ Present Part of the Time
- ☐ No Interference with Normal Life
- ☐ Considerable Interference with Normal Life
- ☐ Present Most of the Time
- ☐ Present Rarely
- ☐ Slight Interference with Normal Life
- ☐ Prevents Some Normal Activities

SYMPTOMS ARE WORSE

- ☐ Outdoors, and better indoors
- ☐ In the bedroom or when in bed
- ☐ During wet or damp weather
- ☐ During known pollen seasons
- ☐ When exposed to tobacco smoke
- ☐ When sweeping or dusting the house
- ☐ In air conditioning
- ☐ Tobacco smoke bothers me more than anything else
- ☐ At nighttime
- ☐ During windy weather
- ☐ When the weather changes
- ☐ In certain rooms or buildings
- ☐ With yard work, cut grass, leaves, hay or barns
- ☐ In areas with mold or mildew
- ☐ In fields or in the country

SYMPTOMS ARE BETTER

- ☐ After shower or bath
- ☐ Indoors
- ☐ After taking antihistamines
- ☐ In air conditioning
- ☐ During or after physical activity
- ☐ With allergy shots

What makes you feel better? _____

ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

- ☐ Dogs
- ☐ Horses or Cattle
- ☐ Rabbits
- ☐ Bees
- ☐ None
- ☐ Cats
- ☐ Rodents (mice, guinea pigs, etc.)
- ☐ Birds or Feathers
- ☐ Other _____

FOOD RELATED SYMPTOMS

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

FOODS THAT CAUSE SYMPTOMS FROM <u>ONE HOUR TO THREE DAYS</u> AFTER EXPOSURE.

- ☐ Eggs
- ☐ Beef
- ☐ Wheat
- ☐ Peanut
- ☐ Fish
- ☐ Orange or other citrus
- ☐ Chocolate
- ☐ Yeast
- ☐ Other: _____
- ☐ Milk
- ☐ Corn
- ☐ Soybean
- ☐ Pork
- ☐ Shellfish
- ☐ Potato
- ☐ Tomato
- ☐ Coffee or Tea

CHEMICALS THAT CAUSE SYMPTOMS

- ☐ Insecticides & Pesticides
- ☐ Perfumes & Cosmetics
- ☐ Stove or Furnace Emissions
- ☐ Chemicals in the workplace
- ☐ Newsprint
- ☐ None
- ☐ Paints & Household Cleaners
- ☐ Gasoline or Automobiles Exhaust
- ☐ The Smell of New Fabrics or Fabric Store
- ☐ Laundry Detergent
- ☐ Other: _____

WHEN ARE YOUR SYMPTOMS WORSE: ☐ Year Round?

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

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, Cytoxan, Cyclosporine, Tacrolimus, etc.)

☐ **Chemotherapy**

Please list any medications that you are currently taking: _____
_____

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 reactions? ☐ 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 your symptoms worse while at work? ☐ Yes ☐ No

If yes, briefly explain: _____

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

ANYTHING YOU WOULD LIKE TO ASK? _____
_____

PLEASE CHECK OFF THE FOLLOWING THAT APPLY TO YOU:

Digestive Track
__ nausea & vomiting
__ diarrhea
__ constipation
__ bloated feeling
__ stomach pains or cramps
__ heart burn
__ blood and/or Mucous in stools

Ears
__ itchy ears
__ ear aches/ear infections
__ drainage from ear
__ ringing in ears
__ hearing loss
__ reddening of ears

Emotions
__ mood swings
__ anxiety/fear/nervousness
__ anger/irritability/aggressiveness
__ argumentative
__ frustrated/cries easily
__ depression

Eyes
__ watery or itchy eyes
__ red/swollen/itchy eyelids
__ bags or dark circles under eyes
__ blurred or tunnel vision

Head
__ headaches
__ faintness
__ dizziness
__ insomnia/sleep disorder
__ facial flushing

Heart
__ irregular/Skipped Heartbeat
__ rapid/Pounding Heartbeat
__ chest Pain

Joints & Muscles
__ pains/aches in joints
__ arthritis/osteoarthritis
__ stiffness/limited movement
__ pain/aches in muscles
__ feeling weak/tired
__ swollen/tender joints
__ growing pains in legs
__ psoriatic/Gouty Arthritis
__ rheumatoid Arthritis

Lungs
__ chest congestion
__ bronchitis
__ shortness of breath
__ difficulty breathing
__ persistent cough
__ wheezing

Mind
__ poor memory
__ difficulty completing projects
__ difficulty with mathematics
__ underachiever
__ poor/short attention span
__ confusion
__ easily distracted
__ difficulty making decisions
__ mild learning Disabilities

Mouth & Throat Thrush
__ chronic coughing
__ gagging/clearing throat often
__ sore throat/hoarse voice/voice loss
__ swollen/discolored tongue/lips
__ canker sores
__ itching on roof of mouth

Nose
__ stuffy nose
__ chronically red/inflamed nose
__ sinus problems
__ hay fever
__ sneezing attacks
__ excessive mucous formation

Skin
__ acne
__ itching
__ hives/rash/dry skin
__ hair loss
__ flushing/hot flashes

Weight
__ binge eating/drinking
__ craving certain foods
__ excessive weight
__ compulsive eating
__ water retention

General
__ frequent illness
__ frequent/urgent urination
__ genital itch/discharge
__ anal itching

Genitourinary
__ kidney problems
__ urinary tract
__ bladder
__ yeast infections

Other Conditions
__ Autism
__ A.D.H.D.
__ A.D.D.
__ Psoriasis
__ Eczema
__ Auto Immune Disorder
__ Chronic Fatigue
__ Multiple Chemical Sensitivities
__ Asthma
__ Congestive Heart Failure
__ Severe Diabetic
__ Severe Depression
__ Obsessive Compulsive

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