INTAKE QUESTIONNAIRE

Patient Name: ______________________________ **Date:** ______________________________

Address: ______________________________ **Date of Birth:** ____________________

City, State, Zip: ______________________________ **Home#:** ______________________________

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

Primary Care Physician: ______________________________ **Referring Physician:** ______________

Who can we thank for Referring you? ____________________________

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.*
- *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**: ______________________________

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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 41 and over)

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? __________________________

FAMILY MEMBERS WITH SIMILAR SYMPTOMS

- ☐ Mother
- ☐ Father
- ☐ Brother/Sister
- ☐ Grandparents
- ☐ Son/Daughter
- ☐ Spouse
- ☐ None

FREQUENCY & SEVERITY OF 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
- ☐ Tobacco smoke bothers me more than anything else

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? ____

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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 ____

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

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
- ☐ Other ______________________________
- ☐ None

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: ______________________________
- ☐ None

WHEN ARE YOUR SYMPTOMS WORSE

- ☐ Year around
- ☐ 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, Cyclosporine, Tacrolimus, etc)
- ☐ Chemotherapy

Please list any medications that you are currently taking: ______________________________

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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 ____

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Are you symptoms worse while at work? ☐ Yes ☐ No

If yes, briefly explain ____

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ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW? _________________________________

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ANYTHING ELSE YOU WOULD LIKE TO ASK? ____

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INFORMED CONSENT
FOR BAX Aura ASSESSMENT

Patient Name________________________ Telephone Number__________

Address____________________________ City & State________________

Background: I desire to be tested to determine possible undesirable reactions to various substances that are natural constituents of my diet, environment or body chemistry. I understand that the testing procedure to be used is not generally employed by the majority of physicians for this purpose. I understand that other methods of ~~allergy~~ testing and treatment are available. These have been described to me.

Procedures: I understand that this is a non-invasive procedure (the skin is not pierced). A metal clip is attached to the skin to measure electrical conductivity on the hands. I understand that the facility cannot guarantee any results.

I choose to be tested with the BAX Aura electro dermal. I understand that electro dermal testing has not been scientifically proven to be reliable and that my physician must still rely upon my observations as to the efficacy of the test and any treatment based on the results of this test.

Risks: The procedure is very safe because it measures only changes in the electrical properties of the skin. However, since an electrical signal is used there is a slight risk or electrical burn or shock. Skin irritation or redness may occur at the site of the test. However, any discomfort should be brief. There are generally no risks associated with the substances recommended to bring your body to equilibrium as long as those substances are taken as recommended, but please report any discomfort you may experience from taking these substances to your examiner or physician. Please report any significant health problems (i.e. Diabetes, High Blood Pressure, etc.) to your physician. I understand that there is a risk factor involved in the treatment and that sensitivities may increase. I assume all responsibility for the unpredictable immune reactions that may lead to increased symptoms. I agree to seek immediate medical attention should this occur and understand that this facility does not treat cases of anaphylaxis and I agree to completely disclose all information regarding any life threatening allergies or allergies resulting in anaphylaxis.

Questions: I have been provided with the opportunity to ask any pertinent questions I have regarding the BAX Aura testing procedure, protocol or treatment program.

Free to Decline: I understand that I may decline to participate in the BAX Aura electro dermal testing and can choose instead to have other allergy testing, including scratch test or blood tests for antibodies.

Important: There is no recognized body of scientific evidence to show that an electrically balanced body is more likely to be healthier and you have chosen to participate in this assessment with that understanding. Your physician may need to use other forms of testing in the course of your treatment.

Payment of Services: You are responsible for the payment of the normal and necessary fees associated with the BAX Aura and remedies, supplements, or herbals recommended as a result of that testing, if purchased in this clinic. Your physician may need to use other forms of testing in the course of your treatment.

I have read and understand the above information about BAX Aura and my rights and responsibilities and hereby consent to the use of the BAX Aura System. I consent to the use of clinical reports and results of my case for study, the purpose of advancing clinical knowledge, research and scientific purposes provided that my identity is kept confidential.

Date___________

Name____________________________

Signature___________________________

Signature of Parent or Guardian if Patient is a minor

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PLEASE CHECK OFF THE FOLLOWING THAT APPLY TO YOU:

Digestive Track
__nausea & vomiting
__diarrhea
__constipation
__bloated feeling
__stomah pains or cramps
__heart burn
__blood and /or muccous in stools

Ears
__ear aches/ear infections
__drainage from ear
__ringing in ears
__hearing loss
__reddening of ears

Emotions
__mood swings
__anxiety/fear/nervousness
__anger/irritability
__argumentative
__frustrated/cries easily
__Depression **S**

Eyes
__watery or itchy eyes
__red/swollen/itchy eyelids
__bags or dark circles under eyes
__blurred or tunnel vision

Head
__faintness
__dizziness
__insomnia/sleep disorder
__facial flushing

Heart
__Irregular/Skipped Heartbeat **S**
__Rapid/pounding Heartbeat **S**
__Chest Pain **S**

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 **S**
__Rheumatoid Arthritis **S**

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 Disablilities

Mouth & Thrush
__chronic coughing
__gagging/clearing throat often
__sore throat/hoarse voice/voise 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 retension

General
__frequent illness
__frequent/urgent urination
__genital itch/discharge
__anal itching

Genitourinary
__kidney problems
__urinary tract
__bladder
__yeast infections

Other Conditions
__Autism **S**
__A.D.H.D **S**
__A.D.D. **S**
__Psoriasis **S**
__Eczema **S**
__Auto Immune Disorder **S**
__Chronic Fatigue **S**
__Multiple Chemical Sensitivities **S**
__Asthma **S**
__Congestive Heart Failure **S**
__Severe Diabetic **S**
__Severe Depression **S**
__Obsessive Complusive Disorder **S**

Date:_________________ **Score:**________

Patient Name:_________________________________

OFFICE USE: ☐ **Mild/Moderate 0-8** ☐ **Severe >9**