Parker Pain Relief Clinic

DR. P.A. PAOLUCCI

Chiropractor

Patient Name:________________________ Date:____________________________

Address:____________________________ Date of Birth:_____________________

City, State, Zip:_______________________ Home#:__________________________

Gender (circle 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, drub 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 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?___________________________________

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

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   □ 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?
____

____

ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

□ Dogs □ Cats □ Rodents (mice, guinea pigs, etc.)
□ Horses or cattle □ Rabbits □ Birds or Feathers
□ Bees □ None □ 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 the mouth or tongue
□ Some foods cause upset stomach or vomiting
□ Symptoms occur with restaurant salad bars/Asian food
□ Symptoms occur with any regularly eaten food
□ 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
□ Preservatives, additives or food coloring increase symptoms
□ No problems with food

FOODS THAT CAUSE SYMPTOMS FROM ONE HOUR TO THREE DAYS AFTER EXPOSURE

□ Eggs □ Milk □ Beef
□ Corn □ Wheat □ Soybean
□ Peanut □ Pork □ Fish
□ Shellfish □ Orange/citrus □ Potato
□ Tomato □ Yeast □ Chocolate
□ Coffee/tea □ None □ Other ________________________________

WHEN ARE YOUR SYMPTOMS WORSE

□ January □ February □ March □ April
□ May □ June □ July □ August
□ September □ October □ November □ December
□ Year round

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 OTC'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:

____

____

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 EVALUATION

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

____

____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW?

____

____

ANYTHING ELSE YOU WOULD LIKE TO ASK?

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