The Natural Path, Ltd.

Allergy/Sensitivity Biofeedback Questionnaire and Consent

*Page 1 of 2*

1. Allergic to Bee Stings\_\_\_\_\_\_ Allergic to Latex\_\_\_\_\_\_\_ Allergic to Penicillin\_\_\_\_\_

2. Have you ever had an anaphylactic attack due to an allergy? [ ] Yes [ ] No [ ] Unsure

Do you have or carry an Epi-pen with you? [ ] Yes [ ] No

3. Have you ever been hospitalized due to an allergy attack? \_\_\_\_\_\_\_ Allergy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Allergies to Pets (list all animals and type of reaction) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Environmental Allergies-grass, pollen, dust (list all and type of reaction)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Are your allergies worse in certain months of the year? Which?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Are you currently receiving allergy shots?\_\_\_\_\_\_\_\_\_\_ Do they help?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergy History and General Review of systems (check any signs or symptoms that your allergies cause):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Cough | Itchy/watery eyes | Frequent bronchitis | Shortness of breath | Red eyes |
| Fatigue | Frequent sinusitis | Wheezing/chest tight | Nasal/Sinus Surgery | Wheezing/Rash w/ Asprin |
| Itchy nose | Nasal congestion | Discharge from eyes | Blood in urine | Ear infections |
| Sneezing | Change in weight | Nose bleeds | Hearing loss | Itchy/full/popping ears |
| Snoring | Pain in temples | Pain in cheeks | Feeling depressed | Change in bowel habits |
| Runny nose | Nasal polyps | Itchy skin | Joint pain | Recurrent ear infections |
| Rashes | Lips/tongue swelling | Frequent colds | Decreased smell | Sinus pain |
| Hives | Pain in forehead | Headaches | Difficulty smelling odors | |

Mark With a X if any of these factors make your allergies worse.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Dust | Morning | Daytime | Nighttime | Indoors | Outdoors | Mildew | Odors | Leaves | Pregnancy |
| A/C | Menstruation | Hobbies | Smoke | Cold | Weather | Work | Stress | Cut Grass | Fragrance |

***I live in a/an:***  House [ ] Apartment [ ] for \_\_\_\_\_\_\_ years

**My home has:**

|  |  |  |  |
| --- | --- | --- | --- |
| Cats (how many) | Central A/C | Stuffed animals in bedroom | Plants in house |
| Dogs (how many) | Window Unit A/C | Wall to wall carpeting in bedroom | Washable pillows |
| Other Pets (list) | Radiant Heat | Forced air heat with vents | Feather pillows |

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*Page 2 of 2*

AUTHORIZATION FOR ALLERGY/SENSITIVITY BIOFEEDBACK SCAN

I, the undersigned client, hereby authorize The Natural Path, Ltd. appointed staff to administer such therapy as is necessary. I hereby certify that I understand the advantages and possible complications. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Technician Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_