INTEGRATIVE HEALTH CENTER

Charlie Savoca, L.Ac.
3121 Park Ave, Suite H
Soquel, CA 95073
(831) 479-3760

Patient Name: _____ Date: _____

Address: _____ DOB: _____

City, State, Zip: _____ Phone: _____

Gender (circle one): Male Female E-mail: _____

Primary Care Physician: _____ Referring Physician: _____

Although your history and symptoms are very important to our analysis of your condition, it is also important for us that you understand:

- We do not treat symptoms or diseases
- An allergy is a disease, rather than 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 procedure is safe & 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)

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 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 rash or hives
- ☐ Some foods cause diarrhea
- ☐ Some foods cause headaches
- ☐ Some foods cause asthma
- ☐ No problems with food

FOOD 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
- ☐ Perfumes & Cosmetics
- ☐ Stove or furnace emissions
- ☐ Chemicals in the workplace
- ☐ Newsprint
- ☐ None
- ☐ Paints & Household Cleaners
- ☐ Gasoline or automobile exhaust
- ☐ The smell of new fabrics or fabric store
- ☐ Laundary 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 (Prednasone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus, etc;)
- ☐ Chemotherapy

Please list any medications that you are currently taking: _____

_____

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 MEMEBERS WITH ALLERGIC SYMPTOMS

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

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 night time
- ☐ 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
- ☐ 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
- ☐ Other _____
- ☐ None

SMOKING

Do you presently smoke? ☐ Yes ☐ No If yes, avg. number if cigarettes per day _____

If yes, what age did you start? _____

Does anyone in your home smoke? _____

PREVIOUS ALLERGY EVALUATION

Have you ever seen an allergist? ☐ Yes ☐ No

Have you ever 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 your symptoms worse while at work? ☐ Yes ☐ No

If yes, briefly explain _____

_____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW:

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_____

_____

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_____

_____

ANYHTING ELSE YOU WOULD LIKE TO ASK?

_____

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