INTO GREAT HEALTH
WITH CHARLIE SAVOCA, L.Ac.

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Patient Name: _____ Date: _____

Street Address: _____ Birth date: _____

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:

- An allergy is a symptom or condition rather than a disease
- 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: (circle one)

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: (please circle)

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 salad bars or Asian foods
Symptoms occur with any regularly eaten food
Preservatives/additives 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 <u>ONE HOUR TO THREE DAYS</u> AFTER EXPOSURE: (please circle)

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: (please circle)

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
Laundry detergent
Other: _____

WHEN ARE YOUR SYMPTOMS WORSE: (please circle)

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? (please check)

__ 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 (Asthmacort, 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: _____

_____

_____

PREVIOUS DIAGNOSIS OF ALLERGY: (please circle)

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: (please circle)

Mother
Father
Brother/Sister
Grandparents
Son/Daughter
Spouse
None

SYMPTOMS ARE WORSE: (please circle)

Outdoors and better indoors
At night time
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, 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: (please circle)

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: (please circle)

Dogs	Cats	Rodents (mice, guinea pigs, etc)
Horse/Cattle	Rabbits	Birds or Feathers
Bees	None	Other: _____

SMOKING:

Do you presently smoke? (circle one) Yes No If yes, how much? _____

If yes, what age did you start? _____ Does anyone in your home smoke? _____

PREVIOUS ALLERGY EVALUATION: (please circle)

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: _____

_____

_____

_____

_____

ANYTHING ELSE YOU WOULD LIKE TO ASK? _____

_____

_____

_____

_____