

Intake Forms For Eloise O'Ball RN
Registered Holistic Allergist

Name: _____

Date: _____

How were you referred?

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Magazine Ad/ Article | <input type="checkbox"/> Brochure |
| <input type="checkbox"/> Website/ Online Search | <input type="checkbox"/> Health Show | <input type="checkbox"/> Other _____ |

What problem brings you or your child to this appointment? _____

When did your symptoms begin? _____

Are your symptoms getting worse? Circle: Yes or No

Do you have any of the following symptoms? Please check all that apply.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Nasal Polyps | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Poor Sense of Smell | <input type="checkbox"/> Hives/ Swelling |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Itchy Nose | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Itchy/ Watery Eyes | <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Postnasal Drip | <input type="checkbox"/> Blocked Ears | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Phlegm/ Sputum: Color: _____ | <input type="checkbox"/> Other | | |

Which of the following trigger (or cause) the symptoms? Please check all that apply.

- | | | | |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Grass | <input type="checkbox"/> Dogs | <input type="checkbox"/> Perfumes | <input type="checkbox"/> Pollution |
| <input type="checkbox"/> Hay | <input type="checkbox"/> Horses | <input type="checkbox"/> Insecticides | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Mold & Mildew | <input type="checkbox"/> Other animals | <input type="checkbox"/> Odors | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Basements | <input type="checkbox"/> Alcoholic Beverages | <input type="checkbox"/> Drafts | <input type="checkbox"/> Cold Air |
| <input type="checkbox"/> Leaves | <input type="checkbox"/> Cosmetics | <input type="checkbox"/> House dust | <input type="checkbox"/> Humidity |
| <input type="checkbox"/> Cats | <input type="checkbox"/> Aerosol sprays | <input type="checkbox"/> Smoke | <input type="checkbox"/> Weather Changes |
| <input type="checkbox"/> Latex (rubber) | <input type="checkbox"/> Other: _____ | | |

When are your symptoms worse?

- | | | | |
|-------------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Year Round | | | |
| <input type="checkbox"/> January | <input type="checkbox"/> February | <input type="checkbox"/> March | <input type="checkbox"/> April |
| <input type="checkbox"/> May | <input type="checkbox"/> June | <input type="checkbox"/> July | <input type="checkbox"/> August |
| <input type="checkbox"/> September | <input type="checkbox"/> October | <input type="checkbox"/> November | <input type="checkbox"/> December |

Have you been skin tested? Circle: Yes or No Result: _____

Have you had allergy injections? Circle: Yes or No If yes, when? _____

Have you received drugs such as cortisone, prednisone, methyl prednisone, antibiotics, etc.? Circle: Yes or No

If yes, when? _____

Do you carry an Epipen? Circle: Yes or No

Occupation (current or previous): _____

Any harmful exposure at work or school? _____

Environmental Survey

How long have you lived in your house/apartment? _____

Approximately how old is your house/apartment? _____

Do you live in a: House Apt/ Duplex Condo/ Town House

Do you live: In the city In the suburbs Rural areas

Do you have a basement? Circle: Yes or No

Type of heating system? Hot Air Steam (Radiator) Electric Hot water baseboard

Do you use a: Humidifier Wood/Coal Stove Dehumidifier Air Cleaner

Number of Pets? _____ Indoor or Outdoor? None Cats Dogs Birds Other

Are there any tobacco smokers in your house? Yes or No

Is your bedroom in the basement? Yes or No

Do you have allergy proof encasing for pillow or mattress? Yes or No

What type of pillow do you have? _____

What type of comforter do you have? _____

Type of floor covering in your bedroom: Wall to wall Area rug Animal Skin Bare floor

How old is your mattress? _____ What is your mattress? (I.e. cotton, horsehair, etc.) _____

Do you have air conditioning? Yes or No If yes, Window Unit or Central

Do you have water leaks, mold contamination? Yes or No

Is your home/ apartment excessively humid? Yes or No

Have you had any home renovations in the past: 1-3 months 3-6 months 6-12 months

Have you had any building envelope failure requiring major or minor repairs or moving? Yes or No

Drinking water type: water purifier bottled water tap water

Do you use EMF protection? Yes No Unsure Want more information

Your Past Medical History

Check all that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease/hepatitis | <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> Heartburn/reflux |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart problems/murmur | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Anemia/blood disorder | <input type="checkbox"/> Kidney/Bladder disease | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Loss of hearing |
| <input type="checkbox"/> PMS | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Infertility | <input type="checkbox"/> Menopause |

If yes to any of the above, please explain: _____

Have you had your tonsils or adenoids removed? Yes or No

Have you had ear, nose or sinus surgery? Yes or No

If yes, please explain: _____

Were you born via Caesarean Section? Yes or No

Do you smoke now? Yes or No

Have you smoked before? Yes or No

Do you use recreational drugs? Yes or No Type _____ Frequency _____

Would you like a BIE session to help quit smoking/ drug use: Yes or No

Family History

Who in your family has had?

Asthma: _____

Eczema: _____

Seasonal or Year Round Allergies: _____

Other Allergies (drugs/bees/food/etc): _____

Sinus Problems: _____

Please list any hospitalization regardless of cause: _____

List any food allergies and reactions experienced: _____

List any drug allergies and reactions experienced (i.e. penicillin, aspirin, sulfa, latex, etc): _____

Describe any reaction to insect stings: _____
