

# ALLERGY PATIENT INFORMATION SHEET

**Dr. Julia Lewis, D.C.**

Wellness Solutions/Non-Force Chiropractic Center  
2674 N. First St. Suite 108, San Jose, CA 95134 • (408) 526-9423

Date \_\_\_\_\_ Number (to confirm appointment) \_\_\_\_\_  
Name \_\_\_\_\_ Phone (Home) \_\_\_\_\_ Date Of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Marital Status S M D W  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Telephone (Work) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Spouse's Telephone (Work) \_\_\_\_\_  
Referred By \_\_\_\_\_

Other healthcare providers seen for allergies:  Chiropractors  M.D.s  Acupuncturists  Others \_\_\_\_\_

How long have you had allergies? \_\_\_\_\_ Have your allergies gotten worse over time?  Yes  No

## SYMPTOMS

Please enter : "P" (Previously), "C" (Currently), in front of any of the following historically significant symptoms.  
Leave blank if never or only rarely experienced.

### GENERAL SYMPTOMS

\_\_\_\_\_ Headache  
\_\_\_\_\_ Fever  
\_\_\_\_\_ Chills  
\_\_\_\_\_ Night Sweats  
\_\_\_\_\_ Fainting  
\_\_\_\_\_ Dizziness  
\_\_\_\_\_ Loss of Sleep  
\_\_\_\_\_ Fatigue  
\_\_\_\_\_ Nervousness  
\_\_\_\_\_ Loss of Weight  
\_\_\_\_\_ Weight Gain

### GASTRO-INTESTINAL

\_\_\_\_\_ Poor Appetite  
\_\_\_\_\_ Poor Digestion  
\_\_\_\_\_ Excessive Hunger  
\_\_\_\_\_ Belching or Gas  
\_\_\_\_\_ Nausea  
\_\_\_\_\_ Vomiting  
\_\_\_\_\_ Pain over Stomach  
\_\_\_\_\_ Constipation  
\_\_\_\_\_ Diarrhea  
\_\_\_\_\_ Colon Trouble  
\_\_\_\_\_ Hemorrhoids  
\_\_\_\_\_ Liver Trouble  
\_\_\_\_\_ Gall Bladder Trouble

### CARDIO VASCULAR

\_\_\_\_\_ Rapid Heart  
\_\_\_\_\_ Slow Heart  
\_\_\_\_\_ High Blood Pressure  
\_\_\_\_\_ Low Blood Pressure  
\_\_\_\_\_ Pain over Heart  
\_\_\_\_\_ Previous Heart Trouble  
\_\_\_\_\_ Swelling Ankles  
\_\_\_\_\_ Poor Circulation  
\_\_\_\_\_ Varicose Veins  
\_\_\_\_\_ Strokes

### RESPIRATORY

\_\_\_\_\_ Congestion  
\_\_\_\_\_ Chronic Cough  
\_\_\_\_\_ Spitting Phlegm  
\_\_\_\_\_ Chest Pain  
\_\_\_\_\_ Difficulty Breathing  
\_\_\_\_\_ Wheezing  
\_\_\_\_\_ Sinus  
\_\_\_\_\_ Post nasal drip  
\_\_\_\_\_ Runny nose  
\_\_\_\_\_ Phlegm  
\_\_\_\_\_ Chronic infections

### SKIN

\_\_\_\_\_ Skin Eruptions  
\_\_\_\_\_ Itching  
\_\_\_\_\_ Bruising Easily  
\_\_\_\_\_ Dryness  
\_\_\_\_\_ Boils  
\_\_\_\_\_ Sensitive Skin  
\_\_\_\_\_ Hives  
\_\_\_\_\_ Eczema  
\_\_\_\_\_ Psoriasis  
\_\_\_\_\_ Acne  
\_\_\_\_\_ Other

### GENITO-URINARY

\_\_\_\_\_ Frequent Urination  
\_\_\_\_\_ Painful Urination  
\_\_\_\_\_ Blood In Urine  
\_\_\_\_\_ Kidney Infection  
\_\_\_\_\_ Bed Wetting  
\_\_\_\_\_ Inability to control  
\_\_\_\_\_ Urine  
\_\_\_\_\_ Prostate Trouble

### MENTAL / COGNITIVE

\_\_\_\_\_ Brain fog  
\_\_\_\_\_ Indecisive  
\_\_\_\_\_ Forgetful

### FOR WOMEN ONLY

\_\_\_\_\_ Painful Periods  
\_\_\_\_\_ Excessive Flow  
\_\_\_\_\_ Irregular Cycle  
\_\_\_\_\_ Hot Flashes  
\_\_\_\_\_ Cramps or Backaches  
\_\_\_\_\_ Miscarriage  
\_\_\_\_\_ Vaginal Discharge  
\_\_\_\_\_ Pregnant at this Time

Are there any specific things or circumstances that trigger your symptoms?

Foods \_\_\_\_\_  
Environmental (pollen, mold, perfume, etc.) \_\_\_\_\_  
Stressful situations \_\_\_\_\_  
Other \_\_\_\_\_

Are you presently taking any medication – prescription or over the counter?  No  Yes

What Drugs? \_\_\_\_\_

Is your health (better / worse / same) compared to last year? (Please circle one)

What are you hoping we can do for you at our office? \_\_\_\_\_

Which areas of your life have become less productive or enjoyable as a result of your allergies?  
 On a scale of 1-3, 3 being the worst

Work	0	1	2	3	Eating	0	1	2	3
Social Life	0	1	2	3	Ability to Concentrate	0	1	2	3
Exercise	0	1	2	3	Recreation/Play	0	1	2	3
Travel	0	1	2	3	Sleep/Rest	0	1	2	3

Please circle all stresses of a moderate to extreme nature that apply:

- Childhood stress      School stress      Family stress      Change in lifestyle      Work  
 Abuse      Illness      Personal relationships      Loss of loved one      Job change

**List all Traumas, Injuries, Accidents, Medical Operations/Procedures**

Date	Incident

**What Would You Like MORE Of In Your Life? Check as many as you'd like.**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Sense Of Purpose Or Mission in Life | <input type="checkbox"/> Ability to Handle Stress       | <input type="checkbox"/> Mental Clarity               |
| <input type="checkbox"/> More Productive At Home/Work        | <input type="checkbox"/> Play With Kids/Grandkids Again | <input type="checkbox"/> Greater Sense of Well-Being  |
| <input type="checkbox"/> General Happiness                   | <input type="checkbox"/> Creative Thinking              | <input type="checkbox"/> Feelings Of Connection/Peace |
| <input type="checkbox"/> Ease of Movement                    | <input type="checkbox"/> Better Concentration           | <input type="checkbox"/> Breathe w/ Ease & Fullness   |
| <input type="checkbox"/> Ability To Do Hobbies Again         | <input type="checkbox"/> More Patience                  | <input type="checkbox"/> More Easy-Going              |
| <input type="checkbox"/> Energy/Physical Vitality            | <input type="checkbox"/> Ability To Adapt To Change     | <input type="checkbox"/> Excitement/Interest In Life  |
| <input type="checkbox"/> Other _____                         |   |   |

*Please check the best answer:*

I remember important things in my life by <input type="checkbox"/> what I see. <input type="checkbox"/> what I hear. <input type="checkbox"/> what I feel.	The primary reason I brush my teeth is to <input type="checkbox"/> avoid tooth decay and gum disease. <input type="checkbox"/> make sure I have healthy teeth and gums	When I make decisions I generally <input type="checkbox"/> gather facts and weigh the evidence. <input type="checkbox"/> make the right choice instantly. <input type="checkbox"/> consult my friends and family. <input type="checkbox"/> depend upon how I "feel" about it.
---	--	---

I understand that the payment for the care provided by Dr. Lewis is due at the time of service. I will be provided with a receipt for payment of services which I may send to my insurance company for appropriate reimbursement.

**A missed appointment is a disappointment. If for any reason an appointment cannot be kept, I promise to notify the office at least 24 hours in advance to avoid full appointment charge.**

**Patient Signature/Guardian Authorizing Care**

**Date**

I am covered by Medicare or Advantra Freedom (please circle which one and initial)

Please give me a receipt for my insurance, Medical Savings or Flex Spending Account Yes or No (please circle)