Food Sensitivity Testing Intake Form

The information requested below will assist us in helping you reach your goals safely. Feel free to ask any questions about the information being requested. Please note that all the information provided below will be kept confidential unless permission is granted by you or required by law. Your written permission will be required to release any information.

Name: _____ Date Of Birth: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____

Email: _____ (for office use only)

Who referred you to our office? _____

Have you ever been food tested before? Y / N If yes, please describe your experience (what you did / did not like): _____

_____

_____

Current Treatment (chiropractic, massage, naturopath etc.) _____

_____

Health Goals: List one to five health goals that you would like to attain for yourself, in order of priority. How long have these been a concern for you?

1. _____
2. _____
3. _____
4. _____
5. _____

Nutrition:

Are there any foods you crave or can't live without? _____

_____

Are there any foods that you choose to avoid? Y / N

If yes, which foods and why? _____

_____

How well do you sleep? _____ Bedtime: _____ Waking Time:_____

On a scale of 1-10 (10 being the highest) how would you rate your stress level?

_____

Please Circle Any Of The Following Symptoms You Currently Experience:

Head

Headaches
Faintness
Dizziness
Feeling of fullness in the head
Excessive drowsiness or sleepiness soon
after eating
Insomnia

Eyes, Ears, Nose & Throat

Running nose
Stuffy nose
Excessive mucous formations
Watery eyes
Blurring of vision
Ringing of ears
Fluid in the middle ear
Hearing loss
Recurrent ear infections
Itching ear
Ear drainage
Sore throats
Chronic cough

Heart & Lungs

Palpitations
Increased heart rate
Asthma
Congestion of the chest
Hoarseness

Gastrointestinal

Nausea
Vomiting
Diarrhea
Constipation
Malabsorption
Bloating after meals
Belching
Colitis
Flatulence
Feeling of fullness in the stomach long after finishing a meal
Abdominal pains or cramps

Gagging
Canker Sores
Itching of the roof of the mouth
Recurrent sinusitis

Other Symptoms

Chronic fatigue
Weakness
Muscle aches and pains
Joint aches and pains
Swelling of the hands feet or ankles
Urinary tract symptoms (frequency or urgency)
Vaginal itching
Vaginal discharge
Hunger

Skin

Hives
Rashes
Eczema
Dermatitis
Pallor

Psychological Symptoms

Anxiety or panic attacks
Depression
Agressive behavior
Irritability
Mental dullness
Mental lethargy
Confusion
Excessive daydreaming
Hyperactivity
Restlessness
Learning disabilities
Poor work habits
Slurred speech
Stuttering
Inability to concentrate
Indifference

What influences your food choices (circle one):

Taste Nutrition Price Convenience Family Members Friends

On a scale of 1 to 10 (10 being most) how motivated are you to make a change in your health today? _____

WAIVER AND RELEASE

I, _____ (the "Undersigned"), hereby consent to treatment.

I understand that such procedures are non-invasive.

The Clinic and all of its employees assume no responsibility for medical conditions requiring the attention of a medical doctor, or necessary adjustments to prescribed medications during or after the completion of testing and dietary alterations.

I understand the unpredictable nature of sensitivities / intolerances and related symptoms and that the clinic cannot guarantee any results in the reduction of symptoms. The clinic cannot guarantee that new reactions will not develop in the future.

I understand that the Clinic does not treat cases of anaphylaxis and I agree to fully disclose all information regarding any life-threatening allergies or allergies resulting in anaphylaxis.

_____ No, I do not have any life threatening allergies.
_____ Yes, I have the following allergies that may cause anaphylaxis:
_____

_____

I agree to pay the clinic the standard fee for testing administered.
IN WITNESS THEREOF, the undersigned executed the Agreement as of
DATE:

_____ _____

Signature of Undersigned Signature of Practitioner

_____

Signature of Parent or Legal Guardian