New Life Allergy Treatment Center

"Your Natural Solution to Health"

New Patient Health History

Name_____ Ph#(home)_____(cell) _____

Address _____City_____ State _____

Zip Code _____ Date of Birth D/M/Y _____Age _____ Gender _____

Email Address _____

Do you exercise? _____ How frequently? _____

Hobbies _____

Do you smoke? _____ If so how much? _____

Do you drink alcohol? _____ If so how much? _____

How would you rate your diet? Excellent _____ Fair _____ Poor _____ It varies _____

How would you rate your current level of stress on a scale of 0 – 10? _____

<u>MEDICAL HISTORY</u>

<u>Do you have:</u>

Diabetes _____ **Arthritis _____**

Heart Disease _____ **Use a Pacemaker _____**

Lung Disease _____ **Mental Illness _____**

Asthma _____ **Cancer _____**

Other (please specify) _____

Are you currently pregnant? Yes _____ No _____

Have you ever had an Anaphylactic reaction? Yes _____ No _____ If so, when was your last reaction? _____ Do you carry an epi-pen? _____ Have you ever used it? _____

Have you ever been tested for allergies (shots, medication)? _____

Do you currently take any prescription, over the counter or recreational drugs? _____

Please list _____

Are you currently taking Prednisone? _____ Other steroid medication? _____

List any vitamins or natural supplements you are currently taking _____

_____

Have you stayed overnight in the hospital in the last three years? _____ If so, why? _____

_____

What are your current health concerns (what brings you here today)? _____

_____

How did you hear about NEW LIFE ALLERGY TREATMENT CENTER? _____

If you were referred by someone, please give the name _____

FEES:

Initial assessment and allergy testing …….. $95.00

Allergy treatment …… $55.00

Patients are responsible for all fees on the day of the treatment. Forms to submit to third party insurance companies are available to you on request.

CANCELLATION POLICY:

All rescheduled or canceled appointments require 24 hours notice. You will be charged for missed appointments if 24 hours notice is not given.

I have filled out the above information to the best of my ability and believe it to be accurate. I accept the terms and policies outlined above and understand my responsibilities.

_____ _____

Patient Signature (must be 18 to sign) Date

_____ _____

Name of parent or guardian (please print) Relationship to minor

New Life Allergy Treatment Center
PATIENT CONSENT

I (my ward) understand that New Life Allergy Treatment Centre does not claim to cure any illness or disease with their techniques.

I understand that the procedures used at New Life Allergy Treatment Centre do not disclose disease. Rather, it gives the practitioner an indication as to the substance(s) to which the patient may have energetic incompatibilities.

I understand that the most effective way to avoid symptoms caused by allergies is to avoid the allergen. Exposure to allergens has been known to cause symptoms including: asthma, cough, congestion, diarrhea, eczema, general itching, hay fever, headaches, hives, itchy watery eyes, and sinusitis, post nasal drip, shortness of breath and many others, including death.

The services offered by New Life Allergy Treatment Centre are designed to test sensitivity to known allergens to assist me to determine which allergens to avoid. I understand that that there is no guarantee that all allergens to which I (my ward) may be sensitive to will be identified.

New Life Allergy Treatment Centre employs various procedures that have been known to reduce sensitivity to some allergens in some cases when combined with regular professional medical care. However I understand that there is no guarantee that the procedures in my (my wards) case will be effective.

Therefore I understand that I (my ward) must do my best to avoid the allergen. I (my ward) will seek medical advice and follow my (my wards) doctors instructions at all times.

I understand that I (my ward) am advised to continue all medications and other treatment modalities as they have been prescribed by my Doctor unless otherwise advised by my Doctor.

_____ _____

Patient signature (must be 18 to sign) *Date*

_____ _____

Name of parent or guardian (please print) *Relationship to minor*

New Life Allergy Treatment Center

CANDIDA SYMPTOM ASSESSMENT QUESTIONAIRE

A: Instructions:

Score each symptom between 0-10 depending on severity and the degree to which it applies to you; with 10 indicating a severe symptom and 0 indicating that the symptom does not apply to you.

SYMPTOM	*SCORE*
Aching Muscles	_____
Alcohol Cravings	_____
Anxiety	_____
Bread/Starch Cravings	_____
Bronchitis/Cough	_____
Chest Pain or Tightness	_____
Constipation	_____
Co-ordination Problems	_____
Depression	_____
Disorientation/Confusion	_____
Dizziness	_____
Ear Infections- frequent	_____
Emotionally over-sensitive	_____
Eye Tearing or Burning	_____
Fatigue	_____
Forgetfulness	_____
Foul Smelling Body Odor	_____
Foul Smelling Breath	_____
Frequent Colds and Flus	_____
Frequent Bladder or Prostate infections	_____
Headaches	_____
Heartburn	_____
Hives	_____
Hunger causes shakes or irritability	_____
Infertility or Endometriosis	_____
Intestinal Discomfort/Pain	_____
Intolerant to mold	_____
Irritability/Jumpiness	_____
Itchy Rectum	_____
Itchy Ears/Nose	_____
Joint Pain	_____
Loose Stools	_____

Menstrual Irregularities..... ._____
Mood Swings..... ._____
Mucus in Stools..... ._____
Food Intolerances..... _____
Nasal or Sinus Congestion..... _____
Numbness/Tingling or Burning Sensations..... _____
Oral Thrush..... _____
Panic Attacks..... _____
Perfume/Chemical Sensitivities..... _____
Poor Balance..... ._____
Poor Concentration..... ._____
Post Nasal Drip..... ._____
Psoriasis/Eczema/Skin Rashes..... ._____
Sleep Disturbances..... ._____
Sore Throat (frequent)..... ._____
Spots in Front of Eyes..... ._____
Sugar Cravings..... ._____
Tobacco Smoke Intolerance..... ._____
Vaginal Yeast Infections..... ._____
Weak Digestion/Gas/Bloating..... ._____
Weakness/Trembling..... ._____
White Coating on Tongue..... ._____

A. TOTAL……._____

B. Score 5 points for each of the following questions that applies to you
More than one Pregnancy..... _____
Use of birth control pills for more than six months..... _____
Antibiotics for more than three weeks..... _____
Four or more short antibiotic treatments in a two year period..... _____
Use of any steroid drug for four weeks or more in the last five years. _____

B. TOTAL……._____

TOTAL SCORE A &B:_____

Mild-35 to 55
Moderate-55 to 85
Severe- 85 and higher

This questionnaire is not a definite diagnosis of Candida, as other conditions may produce similar symptoms, but gives your practitioner an indication as to whether or not Candida is a possibility and to make appropriate recommendations.

HIPAA Notice of Privacy Practices Statement

Notice of Information Practices and Privacy Statement for New Life Natural Health Center
Your Physical Address and Complete Contact Information

How We Collect Information About You: New Life Natural Health Center (NLNHC) and its employees and volunteers collect data through a variety of means including but not necessarily limited to phone calls, emails, voice mails, and from the submission of personal information forms that is either required by law, or necessary to process information or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to health forms, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to provide you with health or counseling services which may require communication between NLNHC and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance, If you apply or attempt to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of NLNHC. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission. Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Signed:_____ **Date:**_____