

**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? \_\_\_\_\_

MEDICAL HISTORY

Do you have:

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? \_\_\_\_\_

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

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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.

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Patient Signature (must be 18 to sign)

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Date

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Name of parent or guardian (please print)

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Relationship to minor

# CANDIDA SYMPTOM ASSESSMENT QUESTIONNAIRE

## 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.

<u>SYMPTOMS</u>	<u>SCORE</u>
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 Flues.....	_____
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..... \_\_\_\_\_

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 make appropriate recommendations.

**New Life Allergy Treatment Center**

**PATIENT CONSENT**

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

I understand that the procedures used at New Life Allergy Treatment Center do not disclose disease. Rather, 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, sinusitis, post nasal drip, shortness of breath and many others, including death.

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

New Life Allergy Treatment Center 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 there is no guarantee that the procedures in my (my wards) case will be effective.

Except in the case of gross negligence or malpractice, I or my representative(s) agree to full release and hold harmless Terry Robinson from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).

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 Natural Health Center (NLNHC)**

**Acknowledgement of Receipt of Notice of Privacy Information Practices**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying information to my bill
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

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Patient Name (Please Print)

\_\_\_\_\_  
Signature of Patient                      Date                      Witness                      Date

**If person signing is not patient, please print name below and relationship to patient:**

\_\_\_\_\_  
Printed Name                                      Relationship to Patient