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? _____

_____

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 …….. $150.00

Allergy treatment …….. $60.00

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

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.

SYMPTOMS	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 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.

725 S. Adams Rd, Suite 250, Birmingham, MI 48009 Phone: 248-792-2229

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

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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:

_____

_____

_____

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