



Patient Name: _____ **Date:** _____

Date of Birth: _____ **Age** _____ **Male / Female**

Address: _____

City, State, Zip: _____

Home#: _____ **Cell #:** _____ **Work#:** _____

Spouse/Partner's Name _____ **Parents' Names (if patient is a child)** _____

E-Mail: _____ **How did you hear about us?** _____

Emergency Contact _____ **Phone#** _____

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

- *A symptom is an attempt by your body to tell you something is wrong.*
- *Symptoms/Conditions/Diseases are caused by an overload of stress on your body.*
- *We do not treat symptoms or diseases.*
- *We reduce the stress on your nervous system and your body does the rest!*
- *Our procedures are safe for all ages and painless.*

Briefly describe the reason for your visit and what you hope to accomplish: _____

Goals: Please list your goals (in order of most important to least important) for incorporating the BioVeda System into your health care plan. If it is for relief of a symptom or condition, please grade the severity of your symptom / condition on a scale of 0-10 (0 being no symptom, 10 being the most severe symptom).

1. _____ grade /10
2. _____ grade /10
3. _____ grade /10
4. _____ grade /10
5. _____ grade /10

Did you experience any type of injuries / trauma around the time when your symptoms first started? Describe.

Physical (accident, falls, surgery, wounds): _____

Emotional (abuse, loss of a loved one, extremely high stress): _____

Chemical (toxic exposure, vaccination, medicine reaction): _____

Patient Name: _____

At what age did your symptoms first appear: _____

Have your symptoms ever gone away completely (even for a short period of time) and when? _____

FREQUENCY OF SYMPTOMS (if more than one symptom, label which one applies to each answer)

- | | |
|---|--------------------------------|
| _____ Constant/Chronic with little change | _____ Present most of the time |
| _____ Present part of the time | _____ Present rarely |

SEVERITY OF SYMPTOMS (if more than one symptom, label which one applies to each answer)

- | | |
|--|--|
| _____ Slight interference with normal life | _____ Moderate interference with normal life |
| _____ Severe interference with normal life | _____ No interference with normal life |

SYMPTOMS ARE WORSE (if more than one symptom, label which one applies to each answer)

- | | |
|--------------------------------------|---|
| ▼ Outdoors | ▼ At nighttime |
| ▼ In the bedroom or when in bed | ▼ During windy weather |
| ▼ During wet or damp weather | ▼ When the weather changes |
| ▼ During known pollen seasons | ▼ In certain rooms or buildings |
| ▼ When exposed to tobacco smoke | ▼ With yard work, cut grass, leaves, hay or barns |
| ▼ When sweeping or dusting the house | ▼ In areas with mold or mildew |
| ▼ In air conditioning | ▼ In fields or in the country |

What else makes you feel worse? _____

SYMPTOMS ARE BETTER (if more than one symptom, label which one applies to each answer)

- | | |
|-------------------------------|-------------------------------------|
| ▼ After shower or bath | ▼ In air conditioning |
| ▼ Indoors | ▼ During or after physical activity |
| ▼ After taking antihistamines | |

What else relieves your symptoms? _____

ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

(if more than one symptom, label which one applies to each answer)

- | | | |
|--------------------|-----------|-------------------------------------|
| ▼ Dogs | ▼ Cats | ▼ Rodents (mice, guinea pigs, etc.) |
| ▼ Horses or Cattle | ▼ Rabbits | ▼ Birds or Feathers |
| ▼ Bees | ▼ Other | |

CHEMICALS CAUSE SYMPTOMS (if more than one symptom, label which one applies to each answer)

- | | |
|------------------------------|--|
| ▼ Insecticides & pesticides | ▼ Paints & household cleaners |
| ▼ Perfumes & cosmetics | ▼ Gasoline or automobiles exhaust |
| ▼ Stove or furnace emissions | ▼ The smell of new fabrics or fabric store |
| ▼ Chemicals in the workplace | ▼ Laundry detergent |
| ▼ Newsprint | ▼ Other: _____ |
| ▼ None | |

Patient Name: _____

FOOD RELATED SYMPTOMS (if more than one symptom, label which one applies to each answer)

- | | |
|---|--------------------------------------|
| ▼ Symptoms flare 5-60 minutes after meals | ▼ Some foods are craved or addictive |
| ▼ The smell or odor of some foods increases symptoms | ▼ Some foods cause nasal symptoms |
| ▼ Some foods cause swelling of the mouth or tongue | ▼ Some foods cause rashes or hives |
| ▼ Some foods cause upset stomach or vomiting | ▼ Some foods cause diarrhea |
| ▼ Symptoms occur with restaurant salad bars or Asian foods | ▼ Some foods cause headaches |
| ▼ Symptoms occur with any regularly eaten food | ▼ Some foods cause asthma |
| ▼ Preservatives, additives or food coloring increase symptoms | ▼ No problem with foods |

FOODS THAT CAUSE SYMPTOMS FROM ONE HOUR TO THREE DAYS AFTER EXPOSURE

- | | | |
|-----------------|--------------------------|-------------|
| ▼ Eggs | ▼ Milk | ▼ Beef |
| ▼ Corn | ▼ Wheat | ▼ Soybean |
| ▼ Peanut | ▼ Pork | ▼ Fish |
| ▼ Shellfish | ▼ Orange or other citrus | ▼ Potato |
| ▼ Tomato | ▼ Yeast | ▼ Chocolate |
| ▼ Coffee or Tea | ▼ Other _____ | |
| ▼ None | | |

Please list the foods that you most commonly eat: _____

What is your typical breakfast? _____

What is your typical lunch? _____

What is your typical dinner? _____

WHEN ARE YOUR SYMPTOMS WORSE ▼ **Constant Year Around**

(if more than one symptom, label which one applies to each answer)

- | | | | |
|-------------|------------|------------|------------|
| ▼ January | ▼ February | ▼ March | ▼ April |
| ▼ May | ▼ June | ▼ July | ▼ August |
| ▼ September | ▼ October | ▼ November | ▼ December |

SMOKING

Do you presently smoke? ▼ Yes ▼ No If yes, average number of cigarettes per day? _____

If yes, at what age did you start? _____

Does anyone that you live with smoke? ▼ Yes ▼ No

SCHOOL/WORK ENVIRONMENT

What is your occupation/What level of school are you currently? _____

What Company do you work for or school do you go to? _____

Are you exposed to chemicals or strong odors at work/school? ▼ Yes ▼ No

If yes, briefly explain _____

Are you symptoms worse while at work/school? ▼ Yes ▼ No

If yes, briefly explain _____

Patient Name: _____

FAMILY MEMBERS WITH SIMILAR SYMPTOMS

Mother _____ Father _____
Brother/Sister _____ Grandparents _____
Son/Daughter _____ Spouse _____
v None

ALLERGY EVALUTION HISTORY

Have you ever seen an allergist? v Yes v No
Have you had allergy skin testing? v Yes v No
Have you had blood test for allergies? v Yes v No
Did you have any positive reaction? v Yes v No
If yes, please list positive allergens (include any medications) _____
Have you ever received allergy shots? v Yes v No
Do you take allergy medication? v Yes v No
If yes, did it give you some relief? v Yes v No

Please list all things that have caused a severe allergic reaction (i.e. shellfish, medication, insect bites, stings, etc.) _____

Please list ALL health conditions / problems you currently have: _____

Please list ALL medications that you are currently taking and list what you are taking each for: _____

Please list ALL supplements that you are currently taking and list what you are taking each for: _____

Please list ALL surgeries you have had and the date/year: _____

Please list ALL MAJOR health conditions / problems you have had in the PAST: _____

Please tell us about any additional information you would like us to know. _____

Name _____

PLEASE CHECK OFF THE FOLLOWING THAT APPLY TO YOU:

Digestion

- nausea
- vomiting
- diarrhea
- constipation
- bloated feeling
- stomach pains
- stomach cramps
- heart burn
- blood in stool
- mucous in stool
- IBS (Irritable bowel syndrome)
- Crohn's Disease
- Ulcerative Colitis
- anal itching

Ears

- itchy ears
- ear aches/ear infections
- drainage from ear
- ringing in ears
- hearing loss
- reddening of ears

Emotions

- mood swings
- Bipolar Disorder
- anxiety
- fear
- nervousness
- anger
- irritability
- aggressiveness
- argumentative
- frustrated
- cry easily
- Depression

Eyes

- watery eyes
- itchy eyes
- red eyes
- swollen eyelids or bags
- dark circles under eyes
- blurred vision
- tunnel vision

Head

- headaches
- migraines
- faintness
- dizziness
- light headedness
- facial flushing

Sleep

- insomnia
- sleep disorder
- sleep apnea
- snoring

Heart

- Irregular/Skipped Heartbeat
- Rapid/Pounding Heartbeat
- Chest Pain
- Congestive Heart Failure

Joints & Muscles

- pains/aches in joints
- osteoarthritis
- stiffness/limited movement
- pain/aches in muscles
- feeling weak/tired
- swollen/tender joints
- growing pains in legs
- Psoriatic Arthritis
- Gout
- Rheumatoid Arthritis

Lungs

- chest congestion
- bronchitis (chronic)
- shortness of breath
- difficulty breathing
- persistent cough
- wheezing
- Asthma

Mind

- poor memory
- difficulty completing projects
- difficulty with mathematics
- underachiever
- poor/short attention span
- confusion
- easily distracted
- difficulty making decisions
- mild learning Disabilities
- A.D.H.D.
- A.D.D.

Genitourinary

- kidney problems
- urinary tract
- bladder
- yeast infections (chronic)
- frequent/urgent urination
- genital itch/discharge

Mouth & Throat

- chronic coughing
- gagging/clearing throat often
- sore throat/hoarse voice/voice loss
- swollen/discolored tongue/lips
- canker sores
- itching on roof of mouth

Nose

- stuffy nose
- chronically red/inflamed nose
- sinus problems
- hay fever
- sneezing attacks
- excessive mucous formation

Skin

- acne
- itching
- hives/rash/dry skin
- hair loss
- flushing/hot flashes
- Psoriasis
- Eczema

Weight

- binge eating/drinking
- craving certain foods
- excessive weight
- compulsive eating
- water retention
- underweight

Other Conditions

- Autism
- Auto Immune Disorder(s)
- Chronic Fatigue
- Multiple Chemical Sensitivities
- Diabetic
- Obsessive Compulsive Disorder
- frequent illness

Other _____

