THE DAY OF YOUR APPOINTMENT:

Our testing is performed on a strict time schedule, so please be on time. The following reminders will help make your visit go more smoothly.

- Do NOT take supplements or unnecessary medications for 4 hours before you appointment.
- Please drink a lot of water for 24 hours before your visit. We will need you to be well hydrated.
- Do NOT wear pantyhose or clothes with very tight sleeves, as they will interfere with the testing procedures.
- Do NOT wear jewelry. You may wear your wedding ring.
- Please do NOT take any aspirin or pain medications for 12 hours before testing, if possible.
- Do NOT consume alcohol for 12 hours before your appointment.
- Do NOT wear perfume, strong smelling deodorant, fragrances, essential oils, hand lotion, aftershave or cologne on the day of your visit. (Before of after)
- Please schedule appointment so that you are NOT being tested during the first 3 days of your menstrual cycle.
- If you need to reschedule please do so NO LATER than 2 business days to your appointment to avoid a cancellation fee.
- We may be performing several tests during your visit. You will be filling out an extensive questionnaire and speaking with the doctor. Expect to be here AT LEAST one hour.
- At the end of your visit you may be given some instructions and a list of foods to avoid for 24 hours.
- Please eat BEFORE your appointment. You may be asked to avoid food for a short time after your visit or to eat very little. Do NOT come to the office hungry.

IF YOU RECEIVE TREATMENT ON THE FIRST VISIT:

- You may NOT shop for 8 hours after the visit. So please shop in advance of your visit.
- You may NOT go to a restaurant for 8 hours. (For any reason)
- You may NOT visit a hair salon, barber shop or nail salon for 12 hours after treatment.
- You must avoid all chemicals for 12 hours, so please refuel you automobile before your visit.
- You may NOT bath or shower for 8 hours after treatment so shower before your visit.
- Do NOT chew gum, use mints, drink anything except water or eat anything after arriving for your visit.
- NOT permitted for 12 hours after treatment**: Massage, Acupuncture, vigorous exercise, hot tub, sauna steam room or swimming.**
- You may NOT consume alcohol for 12 hours after treatment.
- Do NOT eat a large meal after treatment.
- You may be given a list of additional things to avoid for 24 hours after treatment.

The restrictions above are designed for the worst-case scenario.

We have designed these suggestions based on years of practical experience. You may be able to break some or al of the rules and do just fine, or you may bend one rule and have to REPEAT the visit. You will have the best chance for success if you follow all of these suggestions. The restrictions are to be followed for 24 hours, a small price to pay for a long-term benefit.

Wendy Ormsby D.C., LLC
Chiropractic Holistic Physician

INFORMED CONSENT

Patient Name ____________________________________ Telephone Number: (___) ____- ______

Address ______________________________ City, State Zip Code _________________, ________

Background: I desire to be tested to determine possible undesirable reactions to various substances that are natural constituents of my diet, environment or body chemistry. I understand that the testing procedure to be used is not generally employed by the majority of physicians for this purpose. I understand that other methods of testing and treatment are available. These have been described to me.

Procedures: I understand that this is a non-invasive procedure where the skin is not pierced. Metal conductors are attached to the skin to measure electrical conductivity on the hands. Additional homeopathic remedies; nutritional supplements and other natural remedies may be used to bring abnormal electrical patterns into equilibrium. I understand the nature of related symptoms are of an unpredictable nature and therefore this facility cannot guarantee any results. **Wendy Ormsby D.C., LLC** cannot guarantee the success nor the longevity of this therapy.

I choose to be tested using the Neurological Stress Reduction Therapy (NSRT) electro dermal system. I understand that NSRT testing has not been scientifically proven to be reliable and that my physician must still rely upon my personal observation as to the effectiveness of the test and any treatment based on the results of this test.

Risks: The procedure is very safe because it measures only changes in the electrical properties of the skin. However, since an electrical signal is used there is a slight, risk of electrical burn or shock. Skin irritation or redness may occur at the site of the test. However, any discomfort should be brief.

There are generally no risks associated with the substances recommended to bring your body to equilibrium as long as these substances are taken as recommended. I agree to immediately report any discomfort I may experience from taking these substances to my examiner or physician. I agree I have reported any and all significant health problems (i.e., Diabetes, High Blood Pressure, etc) to my physician.

I understand that sensitivities may increase during therapy. I assume all responsibility for any unpredictable immunity response and understand that this facility does not treat cases of anaphylaxis and I agree to completely disclose all information regarding any life threatening allergies or allergies resulting in anaphylaxis.

Questions: I have been provided with the opportunity to ask any pertinent questions I have regarding the NSRT testing procedure, protocol, and/or treatment program.

Free to Decline: I understand that I may decline to participate in the NSRT electro dermal testing and can choose instead to have other testing.

Important: There is no recognized body of scientific evidence to show that an electrically balanced body is more likely to be healthier and you have chosen to participate in this assessment with that understanding. Your physician may need to use other forms of testing in the course of your treatment.

Payment of Service: You are responsible for the payment of the normal and necessary fees associated with the NSRT and any remedies, supplements, or herbals recommended as a result of that testing, if purchased in this clinic. Your physician may need to use other forms of testing in the course of your treatment.

I have read and understand the above information about NSRT **and my rights and responsibilities and hereby consent to the use of the NSRT System.** I consent to the use of clinical reports and results of case for study, the purpose of advancing clinical knowledge, research and scientific purposes, provided that my identity is kept confidential.

I understand **Wendy Ormsby D.C., LLC,** practices Neurological Stress Reduction Therapy independently of HealthSource and HealthSource of Brunswick. I agree to hold HealthSource and HealthSource of Brunswick, their successors and assigns, blameless and not liable or obligated to the therapy provided by Wendy Ormsby D.C., LLC.

Signature ____ Date: ________________

Wendy Ormsby D.C., LLC
Chiropractic Holistic Physician

PLEASE CHECK OFF THE FOLLOWING THAT APPLY TO YOU:

Digestive Track
- ☐ nausea & vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ bloated feeling
- ☐ stomach pains or cramps
- ☐ heart burn
- ☐ blood and/or mucous in stools

____ TOTAL

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

____ TOTAL

Emotions
- ☐ mood swings
- ☐ anxiety/fear/nervousness
- ☐ anger/irritability/aggressive-ness
- ☐ argumentative
- ☐ frustrated/cries easily
- ☐ depression

____ TOTAL

Eyes
- ☐ watery or itchy eyes
- ☐ red/Swollen/itchy eyelids
- ☐ bags or dark circles under eyes
- ☐ blurred or tunnel vision

____ TOTAL

Head
- ☐ headaches
- ☐ faintness
- ☐ dizziness
- ☐ insomnia/sleep disorder
- ☐ facial flushing

____ TOTAL

Heart
- ☐ irregular/skipped heartbeat
- ☐ rapid/pounding heartbeat
- ☐ chest pain

____ TOTAL

Joints & Muscles
- ☐ pains/aches in joints
- ☐ arthritis/osteoarthritis
- ☐ stiffness/limited movement
- ☐ pain/aches in muscles
- ☐ feeling weak/tired
- ☐ swollen/tender joints
- ☐ growing pains in legs
- ☐ psoriatic/gouty arthritis

____ TOTAL

Lungs
- ☐ chest congestion
- ☐ asthma/bronchitis
- ☐ shortness of breath
- ☐ difficulty breathing
- ☐ persistent cough
- ☐ wheezing

____ TOTAL

Mind
- ☐ poor memory
- ☐ difficulty completing projects
- ☐ difficulty with mathematics
- ☐ underachiever
- ☐ poor/short attention span
- ☐ confusion
- ☐ easily distracted
- ☐ difficulty making decisions
- ☐ learning disabilities

____ TOTAL

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

____ TOTAL

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

____ TOTAL

Skin
- ☐ acne
- ☐ itching
- ☐ hives/rash/dry skin
- ☐ hair loss
- ☐ flushing/hot flashes

____ TOTAL

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

____ TOTAL

Other
- ☐ frequent illness
- ☐ frequent/urgent urination
- ☐ genital itch/discharge
- ☐ anal itching

____ TOTAL

Genitourinary
- ☐ kidney
- ☐ urinary tract
- ☐ bladder
- ☐ yeast infections

Wendy Ormsby D.C., LLC
Chiropractic Holistic Physician

ALLERGY QUESTIONNAIRE

Patient Name: ______________________________ Date: ______________________

Address: ______________________________ Date of Birth: ______________________

City, State, Zip ______________________________ Home#: ______________________

Gender: ☐ MALE ☐ FEMALE Work#: ______________________

Primary Care Physician: ______________________ Referring Physician: ______________________

Insurance: ______________________________

Please answer the questions on this form as they relate to the person being evaluated.

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

- We do not treat symptoms or diseases.
- Allergy is not a disease, rather a condition.
- A symptom is an attempt by your body to tell you something.
- We will attempt to find the underlying cause.
- We do not use drugs in this program.
- There is no single "healthy" diet that will work for everyone.
- Just because food is considered "healthy", does not mean it is "healthy" for you.
- Your diet consists of everything you eat, drink, rub on your skin, or inhale.
- Our procedures are safe and painless.

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

MEDICAL HISTORY/SYMPTOMS REVIEW:

1. Do you have problems with a heart valve, heart murmur, or congenital heart disease? ☐ Yes ☐ No
   If yes, please explain: ____
   ____

2. Do you have an illness that affects your immune system (Common Variable Immunodeficiency, HIV/AIDS, Other Immunodeficiency)? ☐ Yes ☐ No
   If yes, please specify: ____

3. Do you have an autoimmune disease (Lupus, Rheumatoid Arthritis, Sarcoid, Scleroderma, etc.)
   ☐ Yes ☐ No

If yes, please specify: ____
(medical history/symptoms review, continued)

4. Do you have cancer? (Lymphoma, Leukemia, Multiple Myeloma, other) ☐ Yes ☐ No
   If yes, please specify: ____

5. Have you ever had a bone marrow or solid organ transplant? (Lung, Kidney, Liver) ☐ Yes ☐ No
   If yes, please specify: ____

6. Do you have problem with your spleen, lack of spleen or sickle cell anemia ☐ Yes ☐ No
   If yes, please specify: ____

7. Do you have chronic back pain, problems with your discs, sciatica or carpel tunnel? ☐ Yes ☐ No
   If yes, please specify: ____

Do you have recurrent or chronic problems with any of the following?

☐ Frequent Headaches
☐ Vision Disturbance/Cataracts
☐ Wear Glasses
☐ Wear Contacts/Soft/Gas Perm
☐ Frequent Colds, ___ /Year
☐ Diabetes
☐ Anemia/Blood Disorders
☐ Gynecologic Problems
☐ Asthma
☐ Migraines
☐ Peptic Ulcer
☐ Depression
☐ Chest Pain
☐ Pneumonia
☐ High Blood Pressure
☐ Rapid Heart Beat
☐ Nausea/Vomiting
☐ Kidney/Bladder Disease
☐ Liver Disease/Hepatitis
☐ Glaucoma
☐ Osteoporosis
☐ Anxiety
☐ Loss of Hearing
☐ Nausea/Vomiting
☐ Heartburn/Reflux
☐ Constipation
☐ Diarrhea
☐ Frequent/Painful Urination
☐ Arthritis
☐ Cancer
☐ Heart Problem/murmur
☐ Hay Fever
☐ Seizures
☐ Thyroid Disease
☐ Emphysema
☐ Arthritis

If yes to any above, please explain:
____
____
____

Briefly explain any other chronic symptoms:
____
____
____

AGE WHEN SYMPTOMS WERE FIRST OBSERVED

☐ Infant (Age 0-2)
☐ Child (Age 3-5)
☐ Child (Age 6-12)
☐ Adolescent (Age 13-18)
☐ Adult (Age 19-25)
☐ Adult (Age 26-40)
☐ Adult (Age 40+)

PREVIOUS DIAGNOSIS OF ALLERGY

- ☐ Yes, and allergy shots helped
- ☐ Yes, but allergy shots did not help
- ☐ Yes, and medication helped
- ☐ Yes, but medication did not help
- ☐ None

FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

- ☐ Mother
- ☐ Father
- ☐ Brother/sister
- ☐ Grandparents
- ☐ Son/daughter
- ☐ Spouse
- ☐ None

SKIN SYMPTOMS

- ☐ Hives
- ☐ Rashes
- ☐ Itching
- ☐ Eczema
- ☐ Swelling
- ☐ Sores
- ☐ Once had rashes in the bends of the knees or elbows
- ☐ Above symptoms are worse during known pollen seasons
- ☐ Above symptoms are worse with animal exposure
- ☐ Skin problem are rare
- ☐ Skin problems are chronic
- ☐ None

EYE SYMPTOMS

- ☐ Itching
- ☐ Excessive watering
- ☐ Redness
- ☐ Swelling
- ☐ Above symptoms are worse during known pollen seasons
- ☐ Above symptoms are worse with animal exposure
- ☐ Tobacco smoke or chemical exposure makes symptoms worse
- ☐ Tobacco smoke or chemical exposure is the major cause of symptoms

(Eye Symptoms cont)

- ☐ None

NASAL SYMPTOMS

- ☐ Itching
- ☐ Sneezing
- ☐ Runny nose - Clear Discharge
- ☐ Frequent nose blowing
- ☐ Above symptoms are worse during known pollen seasons
- ☐ Above symptoms are worse with animal exposure
- ☐ Runny nose - stuffiness
- ☐ Post nasal drip
- ☐ Frequent sinus infections
- ☐ Nasal obstruction
- ☐ Loss of smell
- ☐ None

EAR SYMPTOMS

- ☐ Itching
- ☐ Blocking, fullness, or popping
- ☐ Hearing loss
- ☐ Pain
- ☐ Frequent ear infections
- ☐ Ear tubes inserted
- ☐ Ringing in ears
- ☐ None

THROAT & MOUTH SYMPTOMS

- ☐ Itching of the throat or mouth
- ☐ Frequent sore throats
- ☐ Frequent laryngitis
- ☐ Frequent tonsillitis
- ☐ Mouth sores
- ☐ Swelling of the tongue or mouth
- ☐ None

CHEST SYMPTOMS

- ☐ Tightness
- ☐ Asthma or wheezing with exercise
- ☐ Asthma or wheezing when around animals
- ☐ Asthma or wheezing during pollen seasons
- ☐ Asthma or wheezing when around tobacco smoke or chemicals
- ☐ Shortness of breath

(Chest Symptoms cont)

- ☐ Dry Coughing
- ☐ Wet Coughing
- ☐ Emphysema
- ☐ Frequent Bronchitis
- ☐ Recurring Pneumonia
- ☐ Chest Pain
- ☐ None

CHRONIC GASTROINTESTINAL SYMPTOMS

- ☐ Nausea and Vomiting
- ☐ Diarrhea
- ☐ Gas, Heartburn
- ☐ Cramps or Bloating
- ☐ Abdominal Pain
- ☐ Re-taste Foods
- ☐ None

BONE & JOINT SYMPTOMS

- ☐ Joint or Bone Pain
- ☐ Muscle Pain
- ☐ Redness or Swelling of Joints
- ☐ Joint Stiffness, Limited Motion
- ☐ None

FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS

- ☐ Constant, Chronic with Little Change
- ☐ Present Most of the Time
- ☐ Present Part of the Time
- ☐ Present Rarely
- ☐ No Interference with Normal Life
- ☐ Slight Interference with Normal Life
- ☐ Considerable Interference with Normal Life
- ☐ Prevents Some Normal Activities

SYMPTOMS ARE WORSE

- ☐ Outdoors, and better indoors
- ☐ At nighttime
- ☐ In the bedroom or when in bed
- ☐ During windy weather
- ☐ During wet or damp weather
- ☐ When the weather changes

(Symptoms Are Worse cont)
- ☐ 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
- ☐ Tobacco smoke bothers me more than anything else
- ☐ Don't know

SYMPTOMS ARE BETTER
- ☐ After shower or bath
- ☐ In air conditioning
- ☐ Indoors
- ☐ During or after physical activity
- ☐ After taking antihistamines
- ☐ With allergy shots
- ☐ Don't know

ANIMAL, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE
- ☐ Dogs
- ☐ Cats
- ☐ Horses or Cattle
- ☐ Rodents (mice, guinea pigs, etc.)
- ☐ Rabbits
- ☐ Birds or Feathers
- ☐ Bees
- ☐ Other: ________________
- ☐ None

FOOD RELATED SYMPTOMS
- ☐ Symptoms flare 5-60 minutes after meals
- ☐ Some foods are craved or addictive
- ☐ The smell or odor of some foods increases symptoms
- ☐ Preservatives, additives or food colorings increase symptoms
- ☐ Some foods cause nasal symptoms
- ☐ Some foods cause asthma
- ☐ Some foods cause rashes or hives
- ☐ Some foods cause headaches
- ☐ Some foods cause swelling of mouth or tongue
- ☐ Some foods cause upset stomach or vomiting
- ☐ Some foods cause diarrhea
- ☐ Symptoms occur with restaurant salad bars or Asian foods
- ☐ Symptoms occur with any regularly eaten food
- ☐ None

FOODS THAT CAUSE SYMPTOMS WITHIN 1-2 HOURS
- ☐ Eggs
- ☐ Milk
- ☐ Beef
- ☐ Corn
- ☐ Wheat
- ☐ Soybean
- ☐ Peanut
- ☐ Pork
- ☐ Fish
- ☐ Shellfish
- ☐ Orange or other citrus
- ☐ Potato

(Foods That Cause Symptoms Within 1-2 Hours cont)
- ☐ Tomato
- ☐ Yeast
- ☐ Chocolate
- ☐ Coffee or Tea
- ☐ Other: __________

FOODS THAT CAUSE SYMPTOMS WITHIN 2-24 HOURS
- ☐ Eggs
- ☐ Milk
- ☐ Beef
- ☐ Corn
- ☐ Wheat
- ☐ Soybean
- ☐ Peanut
- ☐ Pork
- ☐ Fish
- ☐ Shellfish
- ☐ Orange or other citrus
- ☐ Potato
- ☐ Tomato
- ☐ Yeast
- ☐ Chocolate
- ☐ Coffee or Tea
- ☐ Other: ________________

CHEMICALS THAT CAUSE SYMPTOMS
- ☐ Insecticides & Pesticides
- ☐ Paints & Household Cleaners
- ☐ Perfumes & Cosmetics
- ☐ Gasoline or Automobile Exhaust
- ☐ Stove or Furnace Emissions
- ☐ The Smell of New Fabrics or Fabric Stores
- ☐ Chemical in the Workplace
- ☐ Laundry Detergent
- ☐ Newsprint
- ☐ Other: ________________
- ☐ None

When are your symptoms worse: Year Round: ☐ Yes ☐ No

☐ January	☐ February	☐ March
☐ April	☐ May	☐ June
☐ July	☐ August	☐ September
☐ October	☐ November	☐ December

8. Have you had your tonsils or adenoids removed? ☐ Yes ☐ No

9. Have you had ear, nose or sinus surgery? ☐ Yes ☐ No
   If yes, please explain: ____
   ____

10. What is your current weight? ____________ What was your weight 1 year ago? ____________

11. When was your last chest x-ray? __________
    Results: ____

12. Have you ever had sinus x-ray? ☐ Yes ☐ No
    If yes, please explain: ____
    ____
    ____

MEDICATIONS:

1. Do you take any of the following medications on a regular basis?

   ☐ Antihistamines
   (Benadryl, Actifed Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp, Drixoral, Trimalin, Atarax, Claritin, Allegra, Zyrtec, etc.)
   ☐ Bronchodilators
   (Albuterol, Ventolin, Proventil, Serevent, or OTS's such as Primatine Mist, etc.)
   ☐ Steroids Inhalers
   (Asmacort, Flovent, PuJmicort, Beclovent, Aerobid, Advair, etc.)
   ☐ Nasal Steroids
   (Beconase, Flonase, Nasacort, Rhinocort, etc.)
   ☐ Medications that effect the immune system
   (Prednisone, Imuran, Methotrexate, Cellcept, Cytoxan, Cyclosporine, Tacrolimus)
   ☐ Chemotherapy

2. Please list any medications you are currently taking: ____
____

SOCIAL:

1. Where were you born? ____________________ Where were you raised? ____________________
   Where have you lived? ____

2. Check which one applies: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

3. How many children do you have? ____________ What are their ages? ___ ___ ___ ___ ___ ___ ___

4. Do you exercise? ☐ Yes ☐ No
   If yes, how often? _______ /week How long? _______ /workout

5. Do you drink alcohol? ☐ Yes ☐ No
   If yes, how often? _______ Times/week How much? _______ drinks/day

SMOKING:

1. Do you presently smoke? ☐ Yes ☐ No
   If yes, average number of cigarettes per day: ______________
   If yes, at what age did you start? _____________

2. Have you ever smoked? ☐ Yes ☐ No
   If yes, how many years? _____________ When did you quit? _____________
   Average number of cigarettes you smoked per day: _____________

3. Does anyone smoke in your home? ☐ Yes ☐ No

4. Have you ever had a reaction to x-ray dye? ☐ Yes ☐ No
   If yes, please explain: ____
   ____

PREVIOUS ALLERGY EVALUATION:

1. Have you ever seen an allergist? ☐ Yes ☐ No
   If yes allergist's name: ____

2. Have you ever had allergy skin testing? ☐ Yes ☐ No If yes, Date: _________________

3. Did you have any positive reactions? ☐ Yes ☐ No
   If yes, please list positive allergens (include any medications): ____
   ____

4. Have you ever received allergy injections? ☐ Yes ☐ No
   If yes, did your symptoms improve while receiving injections? ☐ Yes ☐ No

5. Have you ever experienced an adverse reaction to an allergy injection? ☐ Yes ☐ No
   If yes, please explain: ____
   ____

6. Have you ever received Cortisone? (Prednisone, Methylprednisolone, etc_) drugs? ☐ Yes ☐ No
   If yes, how long ago? _____________ How much? _________________

ENVIROMENTAL SURVEY:

1. Do your symptoms disturb your sleep? ☐ Yes ☐ No

2. Are your symptoms better when away from home? ☐ Yes ☐ No
   How long have you lived in your house/apartment /condo? _____________

3. Do you live in a: ☐ House ☐ Apartment/Duplex ☐ Condominium/townhouse
   Approximately how many years old is your house/apartment/condo? _____________

4. Do you live in: ☐ The City ☐ The Suburbs ☐ Rural Area

5. Do you have a basement? ☐ Yes ☐ No Is your house built on a slab? ☐ Yes ☐ No

6. Type of heating system: ☐ Hot Air ☐ Steam (radiator) ☐ Electric ☐ Hot Water (baseboard)
   Do you have: ☐ Wood/Coal Stove ☐ Humidifier ☐ Dehumidifier ☐ Air Cleaner

PETS: (This section only for those who own any pets)

How many of the following pets do you own? ______________

☐ Cats ☐ Dogs ☐ Birds ☐ Other: ___________________________
Are they indoor or outdoor pets? ☐ Indoor ☐ Outdoor

SCHOOL HISTORY:

1. Do you attend school? ☐ Yes ☐ No
   If yes, at what grade level? ______________

2. Is your classroom: ☐ Carpeted ☐ Tile ☐ Other
3. Are there any animals in your classroom? ☐ Yes ☐ No
4. Have you missed school due to allergies or asthma? ☐ Yes ☐ No
   If yes, how many days did you miss last year because of allergies or asthma? ______________

WORK ENVIRONMENT:

1. What is your occupation? ______________________ Where are you employed? ________________________
2. How long have you worked there? ______________________
3. Is your workplace: ☐ Carpeted ☐ Tile ☐ Other ______________

4. Is there air conditioning? ☐ Yes ☐ No
5. Is smoking permitted? ☐ Yes ☐ No
6. Are you exposed to chemicals or strong odors? ☐ Yes ☐ No
   If yes, briefly explain: ____
   ____

7. Are your symptoms worse while at work? ☐ Yes ☐ No
   If yes, briefly explain: ____

____

8. Have you missed time from work due to allergies or asthma? ☐ Yes ☐ No
   If yes, how much time have you missed in the past year? __________________

IF THE PATIENT IS A CHILD, PLEASE COMPLETE THE FOLLOWING:

Place of Birth: ______________________ Mother's Age at Birth: _____________

Was Pregnancy/Labor/Delivery Normal? ☐ Yes ☐ No
If no, please explain: ____

Birth Weight: _____________ ☐ Formula ☐ Breast Fed? Well Tolerated? ☐ Yes ☐ No

Has child reached normal growth milestones? ☐ Yes ☐ No
If no, please explain: ____

Your relationship to child: ____