Allergy Wellness Centre

Name_____**Date**_____

Phone Number: _____ **Email** _____ **DOB** _____

PLEASE PRINT and **(CIRCLE)** any appropriate response.

Please describe your symptoms in detail (use other side if necessary): _____

Please list anything that you **believe** you are allergic or sensitive to: _____

What allergies or sensitivities have been **confirmed** by any type of testing? _____

How long have you had your symptoms? _____

Are your symptoms: **mild** **moderate** **severe**

Each year, are your symptoms getting: **better** **worse** **no change**

What doctor-recommended treatment(s) have you had in the past? _____

Were they effective? **No** **Yes...which one(s)?** _____

Please list **all** over-the counter and prescription medications that you are taking and what they are for: _____

What nutritional supplements are you taking? _____

Have you ever had a life-threatening allergic reaction? **No** **Yes...to what?** _____

Do you have: **Celiac Disease** **Liver problems** **Weak immune system** **Lyme Disease**
Adrenal exhaustion **Candida** **N/A**

Allergy Wellness Centre

Do you have recurring: **yeast infections** **athletes foot** **nail fungus** **N/A**
Do you have chronic: **fatigue** **memory problems** **depression** **headaches** **N/A**
Please rate your overall energy level: **poor** **fair** **good** **excellent**
Please rate your overall physical health: **poor** **fair** **good** **excellent**
Please rate your current stress level: **normal** **high** **intolerable**

Please answer <u>all</u> of the questions below.

Do you have: **asthma** **sneezing** **sinusitis** **watery-itchy-swollen eyes** **N/A**
Do you get bacterial infections in your : **sinuses** **lungs** **ears** **N/A**
Do you frequently get colds? **Yes** **No**
What animals do you have?_____

Do fragrances, chemical odors, or second-hand smoke irritate your sinuses or lungs? **Yes** **No**
Do you inhale chemical odors or other fumes on a regular basis? **Yes** **No**
Do you or your spouse use a down/feather pillow or comforter? **Yes** **No**
Has there been any new painting, carpeting, etc. at your home or office during the past 6 months? **Yes** **No**

Are your symptoms worse when you clean the house or garage? **Yes** **No**
Do your symptoms wake you up at night? **Yes** **No**
Are your symptoms worse when you wake up in the morning? **Yes** **No**
Are your symptoms worse in the: **spring** **summer** **fall** **winter** **N/A**
Are your symptoms worse when you are: **indoors** **outdoors** **N/A**
Are your symptoms worse at: **work** **home** **N/A**

Do you have: **indigestion** **bloating** **diarrhea** **constipation** **N/A**
Do you get: **skin rashes** **itching** **hives** **eczema** **headaches** **N/A**
After eating, do you ever feel: **stimulated** **hyperactive** **fatigued** **N/A**
Do you take antacids or acid blocking medications? **Yes** **No**

Please list any food or beverages that seem to cause **any** unpleasant symptoms:

_____
_____

What **specific** food items do you frequently eat for breakfast, lunch, dinner or snacking?

_____
_____

What food or beverages do you **crave**? _____
_____

Which of these do you drink on a regular basis? **coffee** **tea** **milk** **fruit juice** **pop**
diet pop **beer** **wine** **soy milk** **rice milk**
other_____

Have you had any root canals? **Yes** **No** If so, how many? _____

Are you wearing a pacemaker? **Yes** **No**

Allergy Wellness Centre

SYMPTOM SURVEY FORM

INSTRUCTIONS: Number the boxes that apply to you with a 1,2,3.
(1) For mild symptoms (2) for moderate symptoms (3) for severe symptoms.
Leave the box blank if it does not apply to you.

1. ( ) Absent mindedness
2. ( ) Abnormal hair growth
3. ( ) Acid foods upset
4. ( ) Acne
5. ( ) Addiction-smoke
6. ( ) Addiction-sugar
7. ( ) Addiction-alcohol
8. ( ) Addiction-drug
9. ( ) Allergy to drugs
10. ( ) Amnesia-temporary
11. ( ) Anemia
12. ( ) Appetite-excess
13. ( ) Appetite-poor
14. ( ) Arthritis
15. ( ) Asthma-bronchial
16. ( ) Asthma-cardiac
17. ( ) Athletes foot
18. ( ) Bad breath
19. ( ) Blurred vision
20. ( ) Bowel disorders
21. ( ) Brain Fog
22. ( ) Breast-pain
23. ( ) Breast-swelling
24. ( ) Breast-lumps
25. ( ) Bronchitis
26. ( ) Brown spots
27. ( ) Bruise easily
28. ( ) Burning/itching anus
29. ( ) Burning feet
30. ( ) Coated tongue
31. ( ) Cold sweats often
32. ( ) Colds/flues frequent
33. ( ) Colitis
34. ( ) Colon-Gas
35. ( ) Compulsive behaviour
36. ( ) Constipation
37. ( ) Cough
38. ( ) Cradle Cap
39. ( ) Crave Spices
40. ( ) Crave Salts
41. ( ) Crave Sweets
42. ( ) Crave Sour
43. ( ) Crave Onions/beans
44. ( ) Craves Bitters
45. ( ) Cuts heal slowly
46. ( ) Dandruff
47. ( ) Decreased sex drive
48. ( ) Depression
49. ( ) Diabetes
50. ( ) Diarrhea
51. ( ) Difficulty in walking
52. ( ) Difficulty in swallowing
53. ( ) Digestion rapid
54. ( ) Diverticulitis
55. ( ) Dream disturbed sleep
56. ( ) Dry nose
57. ( ) Dry eyes
58. ( ) Dry mouth
59. ( ) Dyslexia
60. ( ) Ear aches
61. ( ) Ear infections
62. ( ) Eating disorder
63. ( ) Eczema
64 ( ) Edema
65. ( ) Elbow pains
66. ( ) Excess thirst
67. ( ) Extremities cold
68. ( ) Eyelids puffy
69. ( ) Eyes watery
70. ( ) Eyes itch
71. ( ) Fainting spells
72. ( ) Falling hair
73. ( ) Fatigue
74. ( ) Feels cold often
75. ( ) Feels insecure
76. ( ) Fever
77. ( ) Forgetfulness
78. ( ) Frequent Rashes
79. ( ) Fungus
80. ( ) Gag easily
81. ( ) Gallstones
82. ( ) Gastric distress
83. ( ) General itching
84. ( ) Greasy food upset
85. ( ) Hair loss
86. ( ) Hay fever
87. ( ) Headache/sinus
88. ( ) Headache/morning
89. ( ) Headache/afternoon
90. ( ) Headache/migraine
91. ( ) Hearing decreased
92. ( ) Heart burn
93. ( ) Heart irregularities
94. ( ) Hemorrhoids
95. ( ) Herpes
96. ( ) High altitude problem
97. ( ) High blood pressure
98. ( ) Hip pains
99. ( ) Hives
100.( ) Hoarseness
101. ( ) Humidity discomfort
102. ( ) Hungry between meals
103. ( ) Hyperactivity
104. ( ) Hysterectomy
105. ( ) Ileocaecal valve
106. ( ) Increased sex drive
107. ( ) Indigestion
108. ( ) Insomnia
109. ( ) Internal trembling
110. ( ) Irritable Bowels
111. ( ) Irritable & restless
112. ( ) Keyed up-fails to calm
113. ( ) Knee pains
114. ( ) Labored breathing
115. ( ) Loss of taste
116. ( ) Low blood pressure
117. ( ) Low back ache
118. ( ) Lump in the throat
119. ( ) Memory loss-short-term
120. ( ) Memory loss long-term
121. ( ) Menses, scanty
122. ( ) Menses, excess
123. ( ) Menses, irregular
124. ( ) Menses, painful
125. ( ) Mental confusion
126. ( ) Metallic taste
127. ( ) Mid back ache
128. ( ) Migrating pains
129. ( ) Milk causes discomfort
130. ( ) Mood swings
131. ( ) Mucous production
132. ( ) Muscle cramps at night
133. ( ) Muscle spasms
134. ( ) Nasal polyps
135. ( ) Nausea
136. ( ) Neck pains
137. ( ) Nervous stomach
138. ( ) Neuralgia
139. ( ) Night sweats
140. ( ) Nose bleed
141. ( ) Numbness
142. ( ) Obsessive behavior
143. ( ) Ovarian cysts
144. ( ) Pain between shoulders
145. ( ) Pain on the heels
146. ( ) Pain – unexplained
147. ( ) Perspiration excess
148. ( ) Phobias
149. ( ) Premenstrual syndrome
150. ( ) Poor memory
151. ( ) Post nasal drip
152. ( ) Premature graying
153. ( ) Prone to infections
154. ( ) Prostate troubles
155. ( ) Psoriasis
156. ( ) Red eyes
157. ( ) Restless leg syndrome
158. ( ) Ring worm
159. ( ) Ringing in the ears
160. ( ) Seizures
161. ( ) Sensitive to cold
162. ( ) Sensitive to heat
163. ( ) Shortness of breath
164. ( ) Shoulder pain
165. ( ) Sigh frequently
166. ( ) Sinusitis
167. ( ) Skin problems
168. ( ) Skin peels
169. ( ) Sleepy during day
170. ( ) Slow pulse
171. ( ) Slow starter
172. ( ) Smell decreased
173. ( ) Sneezing attacks
174. ( ) Sore throat
175. ( ) Sore canker
176. ( ) Sour stomach
177. ( ) Startles easily
178. ( ) Strong light irritates
179. ( ) Swollen ankles, feet
180. ( ) Thickening skin
181. ( ) Thinning skin
182. ( ) Throat constriction
183. ( ) Tightness in the chest
184. ( ) Tingling sensation
185 ( ) Tires too easily
186. ( ) Tourette's syndrome
187 ( ) Upper back ache
188. ( ) Urinary tract disorders
189. ( ) Urination difficult
190. ( ) Urine amount increase
191. ( ) Urine amount reduced
192. ( ) Uterine polyps
193. ( ) Vaginal discharge
194. ( ) Varicose veins
195. ( ) Vomiting frequent
196. ( ) Warts
197. ( ) Weak nails
198. ( ) Weight gain
199. ( ) Weight loss
200. ( ) White spots
201. ( ) Worrier
202. ( ) Yeast infections
203. ( ) Other _____

Allergy Wellness Centre

Candida/Yeast Questionnaire – Adult

Section A – History

Circle the number next to the questions you answer 'yes' then add all the circled numbers and write the total in the box at the bottom.

1. Have you taken tetracycline (Sumycin, Panmycin, Vibramycin, Minocin, etc.) or other antibiotics for acne for 1 month or more?.....**50**

2. Have you at any time in your life, taken other "broad spectrum" antibiotics for respiratory, urinary or other infections for 2 months or more, or for shorter periods, 4 or more times in a 1-year span?.....**50**

3. Have you taken a broad-spectrum antibiotic drug even for 1 period?.....**6**

4. Have you at any time in your life, been bothered by persistent prostatitis, vaginitis, or other problems affecting your reproductive organs?.....**25**

5. Have you been pregnant…
   a) 2 or more times?.....**5**
   b) 1 time?.....**3**

6. Have you taken birth control pills for…
   a) More than 2 years?.....**15**
   b) 6 months to 2 years?.....**8**

7. Have you taken prednisone, Decadron, or other cortisone-type drugs by mouth or inhalation…
   a) For more than 2 weeks?.....**15**
   b) For 2 weeks or less?.....**6**

8. Does exposure to perfumes, insecticides, and fabric shop odors or other chemicals provoke…
   a) Moderate to severe symptoms?.....**20**
   b) Mild symptoms? **5**

9. Are your symptoms worse on damp, muggy days or in moldy places? **20**

10. If you have ever had athlete's foot, ringworm, jock itch or other chronic fungus infections of the skin or nails, have such infections been …
    a) Severe or persistent? **20**
    b) Mild or moderate? **10**

11. Do you crave sugar?.....**10**

12. Do you crave breads?.....**10**

13. Do you crave alcoholic beverages?.....**10**

14. Does tobacco smoke really bother you? **10**

Total Score for Section A:_____

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Section B – Major Symptoms
For each symptom that is present, enter the appropriate number on the adjacent line:

- If a symptom is occasional or mild	**score 3 points**
- If a symptom is frequent of moderately severe	**score 6 points**
- If a symptom is severe and/or disabling	**score 9 points**

Total the score for this section and record them in the box at the bottom of this section.

1. Fatigue or lethargy ..... _____
2. Feeling of being 'drained' ..... _____
3. Poor memory ..... _____
4. Feeling 'spacey' or unreal ..... _____
5. Inability to make decisions ..... _____
6. Numbness, burning or tingling ..... _____
7. Insomnia ..... _____
8. Muscle aches ..... _____
9. Muscle weakness or paralysis ..... _____
10. Pain and/or swelling in joints ..... _____
11. Abdominal pain ..... _____
12. Constipation ..... _____
13. Diarrhea ..... _____
14. Bloating, belching or intestinal gas ..... _____
15. Troublesome vaginal itching or discharge ..... _____
16. Prostatitis ..... _____
17. Impotence ..... _____
18. Loss of sexual desire or feeling ..... _____
19. Endometriosis or infertility ..... _____
20. Cramps and /or other menstrual irregularities ..... _____
21. Premenstrual tension ..... _____
22. Attacks of anxiety or crying ..... _____
23. Cold hands or feet and/or chilliness ..... _____
24. Shaking or irritability when hungry ..... _____

Total Score for Section B: _____

Section C – Minor Symptoms
For each symptom that is present, enter the appropriate number on the adjacent line:

- If a symptom is occasional or mild	**score 3 points**
- If a symptom is frequent of moderately severe	**score 6 points**
- If a symptom is severe and/or disabling	**score 9 points**

Total the score for this section and record them in the box at the bottom of this section.

1. Drowsy....._____
2. Irritable or jittery....._____
3. Lack of coordination....._____
4. Inability to concentrate ....._____
5. Frequent mood swings ....._____
6. Headaches ....._____
7. Dizzy/loss of balance ....._____
8. Pressure above ears… feeling of head swelling ....._____
9. Tendency to bruise easily....._____
10. Chronic rashes or itching ....._____
11. Psoriasis or recurrent hives ....._____
12. Indigestion or heartburn....._____
13. Food sensitivity or intolerance....._____
14. Mucus in stools ....._____
15. Rectal Itching....._____
16. Dry mouth or throat ....._____
17. Rash or blisters in mouth ....._____
18. Bad breath ....._____
19. Foot, hair or body odor not relieved by washing....._____
20. Nasal congestion or post nasal-drip ....._____
21. Nasal itching ....._____
22. Sore throat....._____
23. Laryngitis, loss of voice....._____
24. Cough or recurrent bronchitis ....._____
25. Pain or tightness in chest....._____
26. Wheezing or shortness of breath....._____
27. Urinary frequency, urgency or incontinence ....._____
28. Burning or urination....._____
29. Spots in front of eyes or erratic vision....._____
30. Burning or tearing of eyes....._____
31. Recurrent infections or fluid in ears....._____
32. Ear pain or deafness....._____

Total Score for Section C: _____
Sections A, B, C Grand Total Score: _____

Allergy Wellness Centre

IF YOUR SCORE IS:	**YOUR SYMPTOMS ARE:**
180 or higher (women) 140 or higher (men)	Almost certainly yeast connected
120 (women 90 (men)	Probably yeast connected
60 (women) 40 (men)	Possibly yeast connected
Below 60 (women) Below 40 (men)	Probably not yeast connected

The total score will help you and your practitioner if your health problems are yeast connected. A comprehensive history is also important.

Scores for women will be higher, as 7 items in this questionnaire apply exclusively to women, while only 2 apply exclusively to men.

If your total score for all three sections above was less than 60 for a woman or less than 40 for a man, then you are less likely to have a problem with Candida. However, if you scored higher than this then you may wish to consider lifestyle and dietary changes. A treatment protocol will be discussed and initiated on your first visit.

Allergy Wellness Centre

Patient Doctor Agreement

The results that will be obtained in your care with the Allergy Wellness Centre (AWC) are based on a unique partnership between you, the patient, and Dr. Rob and the AWC. By signing the following agreement, I acknowledge both the Centres responsibility and my own as set out below.

<u>The Centre and specifically Dr. Rob, pledge to you to:</u>

1. Explain our procedure in advance and/or provide you with resources so as to understand the procedures used at the Centre.
2. Value your time and resources and charge a fair price for our services.
3. Constantly strive to improve our service in order to maximize our effectiveness in the minimum amount of visits.
4. Only recommend supplements that are specific to your situation and where possible, offer alternative natural solutions at the least or minimum cost to you the patient.
5. Monitor your progress and make appropriate recommendations including referring you to another health professional when or if such recommendations would be appropriate.
6. Conduct our business with integrity and honesty always keeping your interest at the forefront of what we do.

<u>I acknowledge that my responsibilities are to:</u>

1. Keep my appointments as scheduled. I understand that a missed appointment means a missed opportunity for the clinic to serve someone else. I understand the cancelation policy of the AWC and agree to provide 24 hour notice of changes to my scheduled visit. I understand that failure to notify the office will result in me incurring a full office fee for the missed visit and that no future appointments will be booked until such fee is paid.
2. I understand that it is my responsibility to show up for my appointment on time and that if I or my Dependant are late, that this will affect the amount of time dedicated to my visit and that I will be charged for the visit regardless of how much the Dr will be able to get through in terms of my treatment/protocol.
3. I understand my responsibly is to follow recommendations made at the AWC and understand that where appropriate supplement (which may include drainage remedies, nutrition, probiotic etc.) and/or diet recommendations will be made. I understand that this is part of the protocol and that my results are dependent on my diligence in following said recommendations.
4. I understand that insurance reimbursement is not available for the services performed at the AWC and as a result I am responsible for the financial payment of products purchased and services performed at the time of my visit.
5. I further understand that my health (or dependant) is my responsibility and not the responsibility of the Ontario health care system, my insurance company, my spouse, the AWC or anyone outside of myself.

I acknowledge the above agreement signed this _____ day of _____, 20 _____ .

_____

Patient or Guardian Signature

_____

Dr. Rob Neposlan

Allergy Wellness Centre

I, _____, would like to be evaluated and treated with the Allergy Wellness Centre (AWC) procedures.

I understand that AWC is not a medical diagnostic procedure, and therefore does not diagnose or treat a disease. I understand that the identification of allergens, infectious agents, toxicities, or biochemical dysfunction requires specific medical laboratory procedures, which the AWC evaluation is not a substitute for. Instead, the AWC evaluation is a method by which the body's natural reflexes are used to determine what substance(s) or dysfunction(s) may be causing health problems. AWC treatment is then used to greatly enhance your body's recognition of those specific "health stressors" so that it can effectively correct them.

I understand that AWC treatment is not effective for everyone. I also understand that AWC utilizes Muscle Response Testing, which like any medical testing procedure, is not 100% accurate. I understand that certain medical testing procedures (especially allergy testing) may not reveal the same results as my AWC evaluation. I also understand that other types of alternative care are available, and they have been described to me.

The AWC treatment has been explained to me, and I understand that certain immune responses or detoxification symptoms may result from my treatment. These may include – but are not limited to – fatigue, fever, chills, nausea, headache or body aches. I understand that if any unexpected flare-up of my symptoms should occur, I am responsible for obtaining appropriate medical care for those symptoms.

I understand that I am not being asked to discontinue any other type of care that has been prescribed by my doctor(s), unless otherwise directed by the doctor(s) who prescribed them. I also understand that any improvement in my health which results from my AWC treatment may result in a change in the dosage for my medication which other doctors have prescribed for me. I agree that I will consult my medical provider to determine if my prescription needs to be changed.

I agree to cooperate with my AWC treatment by maintaining a positive attitude concerning my care, continuing treatment with my other health care providers, and telling those providers about any symptoms which may or may not be related to my AWC treatment. I understand that I may discontinue my AWC treatment at any time. However, I understand that the premature termination of my care may be detrimental to any improvement I have obtained.

*Please initial after reading this page*_____

Allergy Wellness Centre

I have read the above statements, and I have been provided the opportunity to ask any questions regarding AWC procedures. I have also been informed that I am to notify my AWC practitioner if I develop any problems during my treatment. I understand the conditions stated above, and hereby consent to participate in this type of care. By signing below, I agree to the terms set forth above.

I have executed the foregoing this _____ day of _____

_____ _____

Patient's Signature Patient's Printed Name

_____ _____

If Minor, signature of parent or guardian Parent or Guardian's Printed Name

_____ _____

Witness Signature Witness Printed Name

Allergy Wellness Centre

FINANCIAL POLICY

INITIAL VISIT (Includes Consultation and Treatment)..... $95.00
TREATMENT VISIT.....$55.00 - $75.00
MISSED APPOINTMENT FEE.....$55.00
Supplements are not included in the treatment fees.

CONSIDERATIONS

I have read and fully understand my financial obligation to the Allergy Wellness Centre. I also understand that insurance reimbursement is not available for the services performed at the AWC and as a result I am responsible for the financial payment of products purchased and services performed at the time of my visit.

_____ _____

Patient/Guardian signature Date