

# Food Sensitivity Testing Intake Form

The information requested below will assist us in helping you reach your goals safely. Feel free to ask any questions about the information being requested. Please note that all the information provided below will be kept confidential unless permission is granted by you or required by law. Your written permission will be required to release any information.

Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_ (for office use only)

**Who referred you to our office?** \_\_\_\_\_

Have you ever been food tested before? Y / N If yes, please describe your experience (what you did / did not like): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Treatment (chiropractic, massage, naturopath etc.) \_\_\_\_\_

\_\_\_\_\_

**Health Goals:** List one to five health goals that you would like to attain for yourself, in order of priority. How long have these been a concern for you?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

**Nutrition:**

Are there any foods you crave or can't live without? \_\_\_\_\_

Are there any foods that you choose to avoid? Y / N

If yes, which foods and why? \_\_\_\_\_

How well do you sleep? \_\_\_\_\_ Bedtime: \_\_\_\_\_ Waking Time: \_\_\_\_\_

On a scale of 1-10 (10 being the highest) how would you rate your stress level?

Please Circle Any Of The Following Symptoms You Currently Experience:

**Head**

- Headaches
- Faintness
- Dizziness
- Feeling of fullness in the head
- Excessive drowsiness or sleepiness soon after eating
- Insomnia

**Eyes, Ears, Nose & Throat**

- Running nose
- Stuffy nose
- Excessive mucous formations
- Watery eyes
- Blurring of vision
- Ringing of ears
- Fluid in the middle ear
- Hearing loss
- Recurrent ear infections
- Itching ear
- Ear drainage
- Sore throats
- Chronic cough

**Heart & Lungs**

- Palpitations
- Increased heart rate
- Asthma
- Congestion of the chest
- Hoarseness

**Gastrointestinal**

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Malabsorption
- Bloating after meals
- Belching
- Colitis
- Flatulence
- Feeling of fullness in the stomach long after finishing a meal
- Abdominal pains or cramps

Gagging  
Canker Sores  
Itching of the roof of the mouth  
Recurrent sinusitis

**Other Symptoms**

Chronic fatigue  
Weakness  
Muscle aches and pains  
Joint aches and pains  
Swelling of the hands feet or ankles  
Urinary tract symptoms (frequency or urgency)  
Vaginal itching  
Vaginal discharge  
Hunger

**Skin**

Hives  
Rashes  
Eczema  
Dermatitis  
Pallor

**Psychological Symptoms**

Anxiety or panic attacks  
Depression  
Agressive behavior  
Irritability  
Mental dullness  
Mental lethargy  
Confusion  
Excessive daydreaming  
Hyperactivity  
Restlessness  
Learning disabilities  
Poor work habits  
Slurred speech  
Stuttering  
Inability to concentrate  
Indifference

What influences your food choices (circle one):

Taste   Nutrition   Price   Convenience   Family Members   Friends

On a scale of 1 to 10 (10 being most) how motivated are you to make a change in your health today? \_\_\_\_\_

**WAIVER AND RELEASE**

I, \_\_\_\_\_ (the "Undersigned"), hereby consent to treatment.

I understand that such procedures are non-invasive.

The Clinic and all of its employees assume no responsibility for medical conditions requiring the attention of a medical doctor, or necessary adjustments to prescribed medications during or after the completion of testing and dietary alterations.

I understand the unpredictable nature of sensitivities / intolerances and related symptoms and that the clinic cannot guarantee any results in the reduction of symptoms. The clinic cannot guarantee that new reactions will not develop in the future.

I understand that the Clinic does not treat cases of anaphylaxis and I agree to fully disclose all information regarding any life-threatening allergies or allergies resulting in anaphylaxis.

\_\_\_\_\_ No, I do not have any life threatening allergies.

\_\_\_\_\_ Yes, I have the following allergies that may cause anaphylaxis:

\_\_\_\_\_  
\_\_\_\_\_

I agree to pay the clinic the standard fee for testing administered.

IN WITNESS THEREOF, the undersigned executed the Agreement as of

DATE:

\_\_\_\_\_  
Signature of Undersigned

\_\_\_\_\_  
Signature of Practitioner

\_\_\_\_\_  
Signature of Parent or Legal Guardian