



Grogan's Park Chiropractic Center - 25144 Grogan's Park Dr
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ALLERGY QUESTIONNAIRE

Patient Name: _____ Date: _____
Address: _____ Date of Birth: _____
City, State, Zip: _____ Home#: _____
Gender (circle one): **MALE** **FEMALE** Work#: _____
Primary Care Physician: _____ Referring Physician: _____

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: _____

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 41 and over)

DID YOU SUFFER FROM ANY TYPE OF PHYSICAL, CHEMICAL OR EMOTIONAL TRAUMA JUST BEFORE YOUR SYMPTOMS WERE FIRST OBSERVED? _____

HAVE YOUR SYMPTOMS EVER GONE AWAY FOR ANY PERIOD OF TIME? _____

FOOD RELATED SYMPTOMS

Symptoms flare 5-60 minutes after meals
The smell or odor of some foods increases symptoms
Some foods cause swelling of the mouth or tongue
Some foods cause upset stomach or vomiting
Symptoms occur with restaurant salad bars or Asian foods
Symptoms occur with any regularly eaten food
Preservatives, additives or food coloring increase symptoms

Some foods are craved or addictive
Some foods cause nasal symptoms
Some foods cause rashes or hives
Some foods cause diarrhea
Some foods cause headaches
Some foods cause asthma
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		

CHEMICALS THAT CAUSE SYMPTOMS

Insecticides & pesticides
Perfumes & cosmetics
Stove or furnace emissions
Chemicals in the workplace
Newsprint
None

Paints & household cleaners
Gasoline or automobiles exhaust
The smell of new fabrics or fabric store
Laundry detergent
Other: _____

WHEN ARE YOUR SYMPTOMS WORSE

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

MEDICATIONS

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)
- Steroid Inhalers (Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair, etc)
- Nasal Steroids (Beconase, Flonase, Nasacort, Rhinocort, etc)
- Medications that affect the immune system (Prednisone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus, etc)
- Chemotherapy

Please list any medications that you are currently taking: _____

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 smoke in your home? Yes No

PREVIOUS ALLERGY EVALUTION

Have you ever seen an allergist? Yes No

Have you had allergy skin testing? Yes No

Did you have any positive reaction? Yes No

If yes, please list positive allergens (include any medications) _____

Have you ever received allergy injections? Yes No

WORK ENVIRONMENT

What is your occupation? _____

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

If yes, briefly explain _____

Are you symptoms worse while at work? Yes No

If yes, briefly explain _____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW? _____

ANYTHING ELSE YOU WOULD LIKE TO ASK? _____
