BIE Client Intake Form

Enlighten Nutrition & Wellness

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Name: ____ Date: __________________

How were you referred?

- ❑ Physician ____
- ❑ Other ____
- ❑ Self Referral ____

What problem brings you or your child to this appointment? ______________________

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When did the symptoms begin? ____

Are your symptoms getting worse? Circle: Yes or No

Do you have any of the following symptoms? Please check all that apply.

❑ Cough	❑ Runny Nose	❑ Nasal Polyps	❑ Eczema
❑ Wheezing	❑ Nasal Congestion	❑ Poor Sense of Smell	❑ Hives/Swelling
❑ Shortness of Breath	❑ Itchy Nose	❑ Ear Infections	❑ Headaches
❑ Chest tightness	❑ Itchy / Watery Eyes	❑ Sinus Infections	❑ Snoring
❑ Sneezing	❑ Postnasal Drip	❑ Blocked Ears	❑ Fatigue
❑ Phlegm/ Sputum:	Color_______________		❑ Other

Which of the following trigger (or cause) the symptoms? Please check all that apply.

❑ Grass	❑ Dogs	❑ Perfumes	❑ Pollution
❑ Hay	❑ Horses	❑ Insecticides	❑ Exercise
❑ Mold & Mildew	❑ Other animals	❑ Odors	❑ Nervousness
❑ Basements	❑ Alcoholic Beverages	❑ Drafts	❑ Cold Air
❑ Leaves	❑ Cosmetics	❑ House dust	❑ Humidity
❑ Cats	❑ Aerosol sprays	❑ Smoke	❑ Weather Changes
❑ Latex (rubber)	❑ Other: ___________		

When are your symptoms worse?

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

Are symptoms better away from home? Circle: Yes or No

If yes, when? ____

Food Stressors Section

Check any symptoms that you have experienced:

- ❑ Abdominal cramping
- ❑ Anaphylactic shock
- ❑ Arthritic type symptoms
- ❑ Canker sores
- ❑ Celiac disease
- ❑ Constipation
- ❑ Depression
- ❑ Diarrhea or loose stools
- ❑ Difficulty concentrating
- ❑ Emotional upset
- ❑ Eczema
- ❑ Fatigue or sudden drops of energy after meals
- ❑ Gas or bloating
- ❑ Heartburn or indigestion
- ❑ Hives
- ❑ Irritable bowel syndrome (IBS)
- ❑ Irritability
- ❑ Itching – skin or rectal
- ❑ Migraine headaches
- ❑ Nausea
- ❑ Nocturnal enuresis (bed wetting)
- ❑ Red rash around mouth, reddening or swelling of skin
- ❑ Rhinitis
- ❑ Runny nose
- ❑ Stiffness of joints
- ❑ Stomach ache
- ❑ Swelling of lips and face
- ❑ Swelling of the joints
- ❑ Vomiting
- ❑ Wheezing

Miscellaneous: Indicate any *additional* information about your symptoms:

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____

Environmental Survey

Occupation (current or previous): ____

Have you had any harmful exposure at work or school? ________________________________

How long have you lived in your house/apartment? ___________________________________

Approximately how old is your house/apartment/condo? ____________________________

Do you live in a: ❑ House ❑ Apt / Duplex ❑ Condo / Town House
Do you live: ❑ In the city ❑ In the suburbs ❑ Rural areas

Do you have a basement? ❑ Yes ❑ No
Is your house built on a slab? ❑ Yes ❑ No

Type of heating system? ❑ Hot Air ❑ Steam(radiator) ❑ Electric ❑ Hot water baseboard

Do you use a: ❑ Humidifier ❑ Wood/Coal Stove ❑ Dehumidifier ❑ Air Cleaner

Of Pets? Indoor / Outdoor? ❑ None ❑ Cats ❑ Dogs ❑ Birds ❑ Other

Are there any tobacco smokers in your house? ❑ Yes ❑ No
Is your bedroom in the basement? ❑ Yes ❑ No
Do you have allergy proof encasing for pillow or mattress ❑ Yes ❑ No

What type of flooring is in your bedroom? ❑ Wall to wall ❑ Area rug ❑ Animal skin ❑ Bare floor

Do you have air conditioning? ❑ Yes ❑ No If yes ❑ Window Unit ❑ Central

What type of pillow do you have? ____
What type of comforter do you have? ____
How old is your mattress? _____________
What is in your mattress? (I.e. cotton, horsehair, latex, memory foam etc.) ______________

Do you have problems with roaches or mice? ❑ Yes ❑ No
Do you have water leaks or mold contamination? ❑ Yes ❑ No
Is your home/apartment excessively humid? ❑ Yes ❑ No

Past Medical History

Check all that apply:

❑ Diabetes	❑ Liver disease/hepatitis	❑ Peptic Ulcer	❑ Heartburn/reflux
❑ Cancer	❑ Heart problems (murmur)	❑ Thyroid disease	❑ Seizures
❑ High blood pressure	❑ Osteoporosis	❑ Arthritis	❑ Migraines
❑ Anemia/blood disorder	❑ Kidney/bladder Disease	❑ Hay fever	❑ Depression
❑ Asthma	❑ Glaucoma	❑ Diarrhea	❑ Anxiety
❑ Back problems	❑ Emphysema	❑ Cataracts	❑ Loss of hearing
❑ PMS	❑ Endometriosis	❑ Infertility	❑ Menopause

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

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Have you had your tonsils or adenoids removed? ❑ Yes ❑ No

Have you had ear, nose or sinus surgery? ❑ Yes ❑ No

If yes, please explain: ____

____

Do you smoke now? ❑ Yes ❑ No How Much? ________________ # Of years? ____

Have you smoked before? ❑ Yes ❑ No When did you stop? _________ # Of years? ____

Family History

Who in your family has had?

Asthma ____

Eczema ____

Sinus Problems ____

Seasonal or Year Round Allergies ____

Other Allergies (drugs/bees/food) ____

Medical History cont'd

Please list any hospitalizations regardless of cause:

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List any food allergies and reactions experienced:

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List any drug allergies and reactions experienced (i.e. penicillin, aspirin, sulfa, latex, etc):

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Describe any reaction to insect stings:

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List all medications & dosages (including nasal sprays, non-allergy medications, alternative/herbal products):

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Patient Name: ____ Date: ______________________
Questionnaire Reviewed:____________________________________ Clinic #: ____________________