New Client Form

Date of Service: ____________________ Current Age: ___________ Date of birth:______________________

Name: _______________________________________ Occupation: ______________________________________

Daytime Phone: ________________________________ Cell Phone: _____________________________________

Email: ____

How did you hear about us?____

Have you ever been to an alternative practitioner? ____

Review of Symptoms

What is your CHIEF COMPLAINT?

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When did your symptoms begin? ____

Are your symptoms getting worse? YES NO

If yes, what exacerbates it? ____

Are your symptoms worse…

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

Are symptoms better away from home? YES NO Worse any time of day? _________________________

Sinus problems? Please clarify____

If I could grant you 3 wishes for improved health, what would they be, in list of priority?

1 ____

2 ____

3 ____

Please list any *known* allergies/intolerances:

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Please list any **anaphylactic** allergies: ____

Have you ever had to use an Epi-pen? YES NO Do you carry one? YES NO

List any **food** allergies & reactions experienced: ____

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List any **drug** allergies & 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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Do you have a **pacemaker**? YES NO

Are you currently **pregnant**? YES NO

Do you have a **seizure** disorder? YES NO

Do you have any shoulder injuries? YES NO SURGERY: Y N Year:____________

What is your stress level? 1 2 3 4 5 6 7 8 9 10

How well do you manage your stress? Very well / Fairly well/ Ok, can do better / Fairly poorly/ Not managed

Do you have anxiety? YES NO What is your anxiety level? 1 2 3 4 5 6 7 8 9 10

Environmental Survey

How long have you lived in your home? ______________________________

Approximately how old is your home? ______________________________

Do you live in a: ❑ House ❑ Apt / Duplex ❑ Condo / TownHouse
Do you live: ❑ In the city ❑ In the suburbs ❑ Rural /Farm areas
Do you have a basement? ❑ Yes ❑ No
Type of heating: ❑ Hot Air ❑ Steam radiator ❑ Electric ❑ Hot water baseboard
Do you use a: ❑ Humidifier ❑ Wood/Coal Stove ❑ Dehumidifier ❑ Air Cleaner

# of Pets: ______________ ❑ None ❑ Cats ❑ Dogs ❑ Birds ❑ Other________

Are there any tobacco smokers in your house? ❑ Yes ❑ No

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

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

Past Medical History

Do you have: (check all that apply)

❑ Acne	❑ Diabetes	❑ High blood pressure	❑ Iron deficiency
❑ Anxiety	❑ Diarrhea	❑ High cholesterol	❑ Lyme
❑ Anemia/Blood disorder	❑ Depression	❑ Heart issues/ murmur	❑ Menopause
❑ Arthritis	❑ Eczema	❑ Heartburn/reflux	❑ Migraines/ PMS
❑ Asthma	❑ Emphysema	❑ Infertility	❑ Osteoporosis
❑ Back problems	❑ Endometriosis	❑ Kidney/Bladder disease	❑ Peptic ulcer
❑ Cancer	❑ Glaucoma	❑ Liver disease/Hepatitis	❑ Seizures
❑ Digestive issues	❑ Hay fever	❑ Autoimmune disease	❑ Thyroid disease

Expand: ____

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Do you smoke now? ❑ Yes ❑ No How Much? ________________ # Of years? ________
Have you smoked ? ❑ Yes ❑ No When did you stop? ____________ # Of years? ________

Check any symptoms you have experienced:

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

Miscellaneous: Indicate any additional information about your symptoms:

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24 Hour Cancellation Policy: Please make every effort to call 48 hours ahead if you are unable to make your appointment. **Repeated cancellations under 24 hours will be charged for 50% of the appointment.**

Payment for services: I agree to pay WithinYou Natural Allergy Relief & Wellness the total due of services rendered by cash or credit card for each BIE clearing session and any supplements that I choose to buy.

Name: ____ Date: __________________

Signature: ____