Healthy Path Inc.

44 Marr Road
Rothesay, NB
E2E 3K6
506-847-0254

Name:____Date:______________________
Address:____________________________________ City:_____________________________
Province:____________________________________ Postal Code:______________________
Telephone:(H)____________________(W)_________________(C)______________________
Email:____
Birth Date:_________________________________ Occupation:_______________________
Family Physician:_____________________________

How did you hear about Healthy Path Inc?____

Have you ever had allergy testing done? Yes_______ No_____
Do you have any known allergies? Yes_______ No_____

If yes, list the allergies and reactions ____
____

Have you ever had an anaphylactic reaction to anything? Yes________ No________
Have you ever been on antibiotics more than twice a year? Yes_______ No________

Health Insurance: ________________ Policy #: ____________ ID#: __________________

Current medications/herbs/vitamins:

Medication name	Reason	Dose
______________________________	______________________________	______
______________________________	______________________________	______
______________________________	______________________________	______
______________________________	______________________________	______

Family history: (allergic tendency is not always inherited directly from the parents. It may skip generations or be manifested in nieces or nephews rather than in direct descendants)

Is there anyone with allergy symptoms in your family?

If so, what? How are they related to you?
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____

Are you or any relatives unable to eat certain foods?
____
____

Indicate any and all medical conditions (I.e. Asthma, Crohn's disease, Heart condition, etc…)

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____

List major surgeries/injuries/treatments that apply to you and date it occurred:

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____
____

Check any events immediately preceding and/or following the first allergic reaction:

___Did you change your diet or go on a special diet?
___Did you eat something new that you haven't eaten for two or three months?
___Did you eat one food repeatedly, every day for a few days?
___Did your symptoms first appear after a major operation?
___Did your symptoms first appear at adolescence or after having a baby?
___Did they appear after an automobile accident or any such major physical or emotional trauma?
___Did they appear after a lengthy exposure to the sun, such as a day at the beach or a game of golf?

Current Symptom Checklist (Rate intensity of symptoms currently present)

Mild=Impacts quality of life, but no significant impairment of day-to-day functioning. **Moderate**=Significant impact on quality of life and/or day-to-day functioning. **Severe**=Profound impact on quality of life and/or day-to-day functioning

Symptom:	Mild	Moderate	Severe	Symptom:	Mild	Moderate	Severe
Abdominal gas/bloating	( )	( )	( )	Hives/dermatitis	( )	( )	( )
Acne	( )	( )	( )	Hyperactivity	( )	( )	( )
Aggressiveness	( )	( )	( )	Inability to concentrate/focus	( )	( )	( )
Anxiety/panic attacks	( )	( )	( )	Increasing food/chemical sensitivities	( )	( )	( )
Arthritic pain (worse on damp days)	( )	( )	( )	Itchy, watery (dry) eyes	( )	( )	( )
Bronchitis (Recurrent)	( )	( )	( )	Lethargy	( )	( )	( )
Chronic anger for no reason	( )	( )	( )	Loss of sex drive	( )	( )	( )
Chronic bad breath	( )	( )	( )	Frequent Memory loss	( )	( )	( )
Chronic indigestion/heartburn	( )	( )	( )	Mental confusion, "brain fog"	( )	( )	( )
Cold extremities	( )	( )	( )	Nasal congestion	( )	( )	( )
Constipation	( )	( )	( )	Phobic/compulsive tendencies	( )	( )	( )
Depression	( )	( )	( )	Psoriasis/eczema	( )	( )	( )
Diarrhea	( )	( )	( )	Skin flushing	( )	( )	( )
Ear problems	( )	( )	( )	Strep throat, recurrent	( )	( )	( )
Eating disorders: Type________	( )	( )	( )	Tonsillitis	( )	( )	( )
Fluid retention	( )	( )	( )	Vaginitis, recurrent	( )	( )	( )
Hair loss	( )	( )	( )	Weight gain/weight loss	( )	( )	( )
Headaches/Migraines	( )	( )	( )	Other (specify)__________________	( )	( )	( )
High cholesterol	( )	( )	( )	______________________________	( )	( )	( )

Is there any other information we need to know?

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