THE ALLERGY CENTRE · JAMISON

Date / /

Name..... Date of Birth ..... Age .....

Sex ..... Single / Relationship Children: Yes / No How many.....

Health Fund ..... Doctor .....

Address.....

Home Tel: ..... Work ..... Mobile .....

Email address ..... How did you hear about us .....

Current occupation .....

Please circle or mark any problem with a **'C'** for *current* and **'P'** for *past*.

- … ADHD
- … Arthritis
- … Arthrosclerosis
- … Asthma / Eczema
- … Back problems
- … Bad Breath
- … Bloating / Wind
- … Cancer
- … Candida / Thrush
- … Chronic Fatigue Syndrome
- … Cold Sores
- … Constant Tiredness
- … Crohns / Ulcerative colitis
- … Cystitis
- … Depression / Low Mood
- … Diabetes
- … Diarrhoea / Constipation
- … Ear Infections
- … Fatty liver / Gallstones
- … Fibromyalgia
- … Forgetfulness / Memory Loss
- … Glandular Fever
- … Haemorrhoids / Fissures
- … Other not listed _____
- … Hay fever
- … Headaches / Migraines
- … Heart Problem
- … High Cholesterol
- … High / Low Blood Pressure
- … Hypo / Hyperglycemia
- … Irritability
- … Irritable Bowel Syndrome
- … Kidney Stones / Spurs
- … Menopausal
- … Menstrual Problems
- … Over Weight / Under Weight
- … PCOS / Fibroids / Endometriosis
- … Pimples/Acne
- … PMT
- … Poor Concentration
- … Post Traumatic Stress
- … Sinusitis / Post Nasal Drip
- … Stomach Cramps / Indigestion
- … Tinea
- … Tinnitus
- … Tonsillitis
- … Ulcers

Family history: health of parents, grandparents, brothers, sisters that may have some bearing on your health:

_____

_____

Current medications:

_____

_____

Current supplements:

_____

_____

_____

Sleep: Great Difficulty falling asleep Wake early Toss all night Wake unrefreshed

Other: _____

Perceived stress level: None 1 2 3 4 5 6 7 8 9 Terrible

Exercise patterns:

_____

_____

_____

Smoker: Yes Past Never **Alcohol intake:** Regular Social Rarely Never

Main reason for visit:

_____

_____

I/WE HEREBY ACKNOWLEDGE THE TEST BEING UNDERTAKEN IS AN INDICATOR TEST ONLY AND NOT A MEDICAL DIAGNOSIS.

Please sign …… Date / /