*Clinic Intake Forms*

|  |  |  |
| --- | --- | --- |
| ***Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |  | ***Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
| **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  | **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  | **Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Gender: MALE \_\_\_ FEMALE \_\_\_** |  | **Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **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 disease.*
* *An 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 underlining 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 (Age 3-5) | € Child (Age 6-12) |
| € Adolescent (Age13-18) | € Adult (age 19-25 | € Adult (Age 26-40) |
| € Adult (Age 41 and over) |  |  |

**PREVIOUS ALLERGY EVALUATION**

|  |  |  |
| --- | --- | --- |
| 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 (including any medications) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Have you ever received allergy injections? \_\_\_\_\_ | | | |
|  | | | |
| **WORK ENVIRONMENT** | | | |
|  | | | |
| What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you exposed to chemicals or strong odors at work? \_\_\_\_\_\_\_ | | | |
| If yes, briefly explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are your symptoms worse while at work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| If yes, briefly explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| ANY ADDITIONAL INFORMATION YOU WOLD LIKE US TO KNOW? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

**WHEN ARE YOUR SYMPTOMS WORSE** Year round

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| € January | € February | € March | € April | € May | € June |
| € July | € August | € September | € October | € 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.) | | | | | | | |
|  | | | | | | | |
| Medication 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 smoke? \_\_\_ Number of cigarettes per day \_\_\_\_ A what age did you start? \_\_\_ Anyone smoke in your house? \_\_\_ | | | | | | | |
|  | | | | | | | |
| **FOOD RELATED SYMPTOMS** | | | | | | | |
|  | | | | | | | |
| € Symptoms flare 5-60 minutes after meals | | | | € Some foods are craved or addictive | | | |
| € The smell or odor of some foods increases symptoms | | | | € Some foods cause nasal symptoms | | | |
| € Some foods cause swelling of the mouth or tongue | | | | € Some foods cause rashes or hives | | | |
| € Some foods causes upset stomach or vomiting | | | | € Some foods cause diarrhea | | | |
| € Symptoms occur with restaurant salad bars or Asian foods | | | | € Some foods causes headaches | | | |
| € Symptoms occur with any regularly eaten food | | | | € Some foods cause asthma | | | |
| € Preservatives, additives or food coloring increases symptoms | | | | € No problem with foods | | | |
|  | | | | | | | |
| **FOODS THAT CAUSES SYMPTOM FROM ONE HOUR TO THREE DAYS AFTER EXPOSURE** | | | | | | | |
|  | | | | | | | |
| € Eggs | € Milk | € Beef | € Corn | | | € Wheat | € Soybean |
| € Peanut | € Pork | € Fish | € Shellfist | | | € Orange/citrus | € Potato |
| € Tomato | € Yeast | € Chocolate | € Coffee/Tea | | | € None | € Other |
|  | | | | | | | |
| **CHEMICALS THAT CAUSE SYMPTOMS** | | | | | | | |
|  | |  | | |  | | |
| € Insecticides & pesticides | | € Paints &household cleaners | | | € Perfumes & cosmetics | | |
| € Gasoline & auto exhaust | | € Stove or furnace emissions | | | € The smell of new fabrics or fabric store | | |
| € Chemicals in the work place | | € Laundry detergent | | | € Newsprint | | |

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ None \_\_\_\_\_\_\_\_\_\_\_\_

**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PREVIOUS DIAGNOSIS OF ALLERGY?**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| € Yes and allergy shots helped | | | € Did not help | | € Yes medication helped | | | € Did not help € None | | |
|  | **FAMILY MEMBERS WITH ALLERGIC SYMPTOMS** | | | | | | | | | |
|  |  | | | | | | | | | |
| € Mother | |  | | € Father | | | € Brother/Sister | | € Grandparents | | |
| € Son/Daughter | |  | | € Spouse | | | € None | |  | | |
|  |  | | | | | | | | |
|  | **FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS** | | | | | | | | |
| € Constant/Chronic with little change | | | | | | € Present most of the time | | | | | |
| € Present part of the time | | | | | | € Present rarely | | | | | |
| € Prevents some normal activities | | | | | | € Considerable interference with normal life | | | | | |
| € Slight interference with normal life | | | | | | € No interference with normal life | | | | | |

**SYMPYOMS ARE WORSE**

|  |  |
| --- | --- |
| € Outdoors and better indorse | € At nighttime |
| € In the bedroom or when in bed | € During windy weather |
| € During wet or damp weather | € When the weather changes |
| € During known pollen seasons | € In certain rooms or buildings |
| € When exposed to tobacco smoke | € With yard work, cut grass, leaves, hay or barns |
| € When sweeping or dusting the house | € In areas with mold or mildew |
| € In air conditioning | € In fields or in the country |
| € Tobacco smoke bothers me more than anything else | |

**SYMTOMS ARE BETTER**

|  |  |  |
| --- | --- | --- |
| € After shower or bath | € In air conditioning | € Indoors |
| € During or after physical activity | € After taking antihistamines | € With allergy shots |

What makes you feel better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ANIMAL, INSECTS AND BIRDS THAT CAUSE SYMTOMS ON EXPOSURE**

|  |  |  |
| --- | --- | --- |
| € Dogs | € Cats | € Horses or Cattle |
| € Rabbits | € Birds or Feathers | € Rodents (mice, guinea pigs, etc.) |
| € Bees | € None | € Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Have You Been Vaccinated Against Communicable Diseases - Yes\_\_\_\_ No\_\_\_**

**Have You experienced and adverse reactions or symptoms after vaccination administered Yes\_\_\_\_ No \_\_\_\_**

**At What Age were symptoms / reactions experienced \_\_\_\_\_\_\_\_\_**

**Name of Vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (age in months,years) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (age in months,years) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (age in months,years) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE CHECK OFF THE FOLLOWING THAT APPLY TO YOU**

|  |  |  |
| --- | --- | --- |
| **Digestive Track** | **Heart** | **Nose** |
| € nausea & vomiting | € irregular/skipped heartbeat | € stuffy nose |
| € diarrhea | € rapid/pounding heartbeat | € chronically red/inflamed nose |
| € constipation | € chest pain | € sinus problems |
| € bloated feeling | TOTAL \_\_\_\_ | € hay fever |
| € stomach pains or cramps |  | € sneezing attacks |
| € heart burn | **Joints & muscles** | € excessive mucous formation |
| € blood and/or mucous in stools | € pains/aches in joints | TOTAL \_\_\_\_ |
| TOTAL \_\_\_\_ | € arthritis/osteoarthritis |  |
|  | € stiffness/limited movement | **Skin** |
| **Ears** | € pain/aches in muscles | € acne |
| € itchy ears | € feeling weak/tired | € itching |
| € ear aches/ear infections | € swollen/tender joints | € hives/rash/dry skin |
| € drainage from ear | € growing pains in legs | € hair loss |
| € ringing in ears | € psoriatic/gouty arthritis | € flushing/hot flashes |
| € hearing loss | TOTAL \_\_\_\_ | TOTAL \_\_\_\_ |
| € reddening of ears |  |  |
| TOTAL \_\_\_\_ | **Lungs** | **Weight** |
|  | € chest congestion | € binge eating/drinking |
| **Emotions** | € asthma/bronchitis | € craving certain foods |
| € mood swings | € shortness of breath | € excessive weight |
| € anxiety/fear/nervousness | € difficult breathing | € compulsive eating |
| € anger/irritability/aggressiveness | € persistent cough | € water retention |
| € argumentative | € wheezing | TOTAL \_\_\_\_ |
| € frustrated/cries easily | TOTAL \_\_\_\_ |  |
| € depression |  | **Genitourinary** |
| TOTAL \_\_\_\_ | **Mind** | € kidney |
|  | € poor memory | € frequent/urgent urination |
| **Eyes** | € difficulty completing projects | € bladder |
| € watery or itchy eyes | € difficulty with mathematics | € yeast infections |
| € red/swollen/itchy eyelids | € underachiever | € genital itch/discharge/anal itching |
| € bags or dark circles under eyes | € poor/short attention | € yeast infections |
| € blurred or tunnel vision | € confusion | TOTAL \_\_\_\_ |
| TOTAL \_\_\_\_ | € easily distracted |  |
|  | € difficulty making decisions | **Other conditions** |
| **Head** | € learning disabilities | € Autism |
| € headaches | TOTAL \_\_\_\_ | € A.D.H.D. |
| € faintness |  | € A.D.D. |
| € dizziness | **Mouth & Throat Thrush** | € Psoriasis |
| € insomnia/sleep disorder | € chronic coughing | € Eczema |
| € facial flushing | € gagging/clearing throat often | € Auto Immune Disorder |
| TOTAL \_\_\_\_ | € sore throat/hoarse voice/voice loss | € Chronic Fatigue |
|  | € swollen/discolored tongue/lips | € Multiple Chemical Sensitivities |
|  | € cancer sores | € Asthma |
|  | € itching on roof of mouth | € Congestive Heart Failure |
|  | TOTAL \_\_\_\_ | € Sever Diabetes |
|  |  | € Severe Depression |
|  |  | € Obsessive Compulsive Disorder |

**Symptoms of Hypothyroidism (Overcoming THYROID Disorders, David Brownstein, MD)**

|  |  |
| --- | --- |
| € Fatigue, sluggishness or weakness | € Swelling of the arms, hands, legs, and fee |
| € Dry skin | € Facial puffiness, especially around the eyes |
| € Brittle nails | € Hoarseness |
| € Hair loss and/or coarse or dry hair | € Muscle aches and cramps |
| € Increased sensitivity to cold | € Low blood pressure |
| € Constipation | € Elevated blood cholesterol |
| € Memory problems or having trouble thinking clearly | € Infertility |
| € Heavy or irregular menstrual periods | € Sleep irregularities |
| € Weight gain | € Depression |

Thytrophin PMG for Hypothyroidism

**Symptoms of Iodine Deficiency (Iodine why you need it, David Brownstein, MD)**

|  |  |
| --- | --- |
| € ADD/ADHD | € Infections |
| € Atherosclerosis | € Keloids |
| € Breast Disease | € Liver Disease |
| € Dupuytren’s Contracture | € Nephrotic Syndrome |
| € Excessive Mucous Production | € Ovarian Disease |
| € Fatigue | € Parotid Duct syndrome |
| € Fibrocystic Breasts | € Peyronie’s |
| € Goiter | € Prostate Disorders |
| € Hemorrhoids | € Sebaceous Cysts |
| € Headaches and Migraine Headaches | € Thyroid Disorders |
| € Hypertension | € Vaginal Infections |

**IODINE PATCH TEST INSTRUCTIONS**

1. Begin the test in the morning (after showering)
2. Use Tincture of Iodine to paint a size of quarter (25 cents) on the inner arm

Tincture of Iodine is available from any drug store or pharmacy. Be sure it’s the

Original orange colored solution not the clear solution. Make the following notes.

* Hour patch begun to lightened :\_\_\_\_\_\_ : \_\_\_\_\_\_ am/pm
* Hour patch disappeared completely:\_\_\_\_\_\_ : \_\_\_\_\_\_ am/pm

1. Write down your starting time:\_\_\_\_\_\_ : \_\_\_\_\_\_ am/pm
2. Observe the coloration of the patch over the next 24 hours.
3. Describe the site after 24 hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Any other observations or comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Patch begins to slightly lighten after 24—NORMAL
* Patch almost disappears in under 24 hours consider **Iodomere** (standard process) 2-3 or more per day
* Patch disappears, or almost in under 10 hours consider **Prolamine Iodine** (standard process) 1-2 or more per day

Repeat patch test ever 2 weeks, when patch no longer disappear after 24 hours lower iodine dose appropriately

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex \_\_\_ Age \_\_\_\_Date \_\_\_/\_\_\_/\_\_\_\_\_

|  |  |
| --- | --- |
| Visit # 1: Date \_\_\_/\_\_\_/\_\_\_\_\_ Multi-Tincture /Total Tincture | |
| Main concern; | |
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| Defibrillator? € Yes € No Are you pregnant? € Yes € No | |
| Visit # 2 Date \_\_\_/\_\_\_/\_\_\_\_\_ **Multi-Tincture/Total Tincture** | |
| Comments | |
| (-) Chronic | (+) Acute |
| € | € |
| € | € |
| € | € |
| € | € |
| € | € |
| € | € |
| Visit # 3 \_\_\_/\_\_\_/\_\_\_\_\_**1X/Mother Tincture** | |
| Comments | |
|  | |
| Visit # 4 Date \_\_\_/\_\_\_/\_\_\_\_\_ **1X/Mother Tincture** | |
| Comments | |
|  | |
| (-) Chronic | (+) Acute |
| € | € |
| € | € |
| € | € |
| € | € |
| € | € |
| € | € |
| **Visit # 5** Date \_\_\_/\_\_\_/\_\_\_\_ | |
| Comments | |
| SRT Antigen Group (environmental triggers) **Multi-Tincture/Total Tincture repeat in MotherTincture/1X** | |
|  | |
|  | |
|  | |
| **Visit # 6** Date | |
| Comments | |
| SRT Sensitivity Group (large group might require 2 visits**) Multi-tincture/Total Tincture repeat in MotherTincture/1X** | |
|  | |
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Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex \_\_\_ Age \_\_\_\_Date \_\_\_/\_\_\_/\_\_\_\_\_

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Advanced procedures go to Pain Management-Chronic fatigue primary symptoms

|  |  |  |
| --- | --- | --- |
| € Abdominal pain | € Diarrhea | € Non allergy rhinitis |
| € Addison disease | € Diet change | € Pain in disc |
| € Allergies to alcohol | € Disc herniation | € Pain in facet joints |
| € Allergies chemicals | € Dizziness | € Pain in sacra iliac joint |
| € Allergies to food | € Dry eyes | € Panic attack s |
| € Allergies medications | € Fainting | € Parkinson disease |
| € Allergies noise | € Fatigue | € Psoriasis |
| € Allergies to odors | € Fibromyalgia | € Rheumatic fever |
| € Alzheimer’s | € Graves’ disease | € Rheumatoid arthritis |
| € Ankylosing spondylitis | € Inflammatory bowel disease | € Shortness of breath |
| € Antibiotic combinations | € Inner ear disease | € Headache new type & severe |
| € Arthritis | € Irritability | € Weather related issues |
| € Bloating | € Jaw pain | € Weight gain |
| € Blurred vision | € Joint disorders | € Diabetes mellitus type 1 |
| € Brain myopathy | € Loss of memory | € Dizziness, balance problems |
| € Chemical sensitivity | € Lyme’s disease | € Panic attack s |
| € Chest pain | € Macular degeneration | € Shortness of breath |
| € Chronic cough | € Memory loss | € Shore throat |
| € Chronic fatigue syndrome | € Menopause | € Tingling sensation |
| € Chronic headache | € Menopause | € Urinary problems |
| € Complex neural pulse | € Menstrual cycle issues | € |
| € Crohns disease | € Menstrual problems | € |
| € Depression | € Nausea | € |
| € Dermatomyositis | € Nerve root Irritation | € |

Thank you for your interest in the BioScanSRT

The day of your appointment:

Our testing is performed on a strict schedule, so please be on time. The following reminders will make your visit go more smoothly.

* Do not take any supplements or unnecessary medications for an hour before your appointment.
* Avoid eating one hour before your appointment.
* Please drink a lot of water for 24 hours before your appointment.
* Most treatments involve acupuncture points on the lower leg, forearms and back. Gowns are provided, but you may want to wear loose pants that can roll up and a white sheer shirt in place of wearing a gown.
* Please do not wear perfume, strong smelling deodorant, fragrances, essential oils, hand lotion, aftershave or cologne on the day of your visit.
* If you need to reschedule your appointment, please do so the day before your appointment.

After your treatment:

For three hours after your treatment we recommend, if possible, do not:

* Shop
* Go to restaurant
* Visit hair salon, Barber shop, or nail salon
* Gas your car
* Chew gum, use breath mints
* Drink anything except water
* Eat anything
* Do anything that is highly stressful or stimulating
* Do not have a massage, Acupuncture, Vigorous Exercise, Hot Tub, Sauna, Steam Room or swimming

(This is to avoid exposure to foods and chemicals that you eat, drink, breath or put on your skin, and is recommended for best results.

You may be able to break some or all of these rules and do just fine, but to have the best results follow all these suggestions. The restrictions are for three hours, a small price to pay for long term benefit.)