HOLISTIC WELLNESS
OTTAWA

Natural Allergy Therapy Intake

Thank you for taking the time to fill out the requested information. Confidential when completed.

PERSONAL INFORMATION **Date:** _____

Name: _____ Date of Birth(dd/mm/yy): _____

What quantity, per day, do you drink on average of the following?
Coffee_____ Tea_____ Milk _____ Herbal tea_____ Alcohol_____ Water_____ Juice_____ Soda_____

List all nutritional supplements you are presently taking (Vitamins, Minerals, Oils, Protein powders etc).
_____
_____

What do you do for exercise, recreation and relaxation?
_____
_____

What do you hope to achieve from this treatment or therapy? _____
_____

What is your chief health concern, how long have you had it? _____
_____

What specialist(s) have you seen? _____

List all medications you are currently taking: _____
_____
_____

List any accidents, injuries, operations and major illnesses you have had:
_____
_____

List any allergens to which you have **SEVERE** reactions(e.g unable to breathe, swelling), and the symptoms they cause:
_____
_____

Have you suffered from any of the following now or in the past? Check all that apply.

Symptom	**x**	**Symptom**	**x**	**Symptom**	**x**
Headache / Migraine	☐	Bladder Infections	☐	Lower back issues	☐
Poor memory	☐	Kidney Infections	☐	Cramps – muscular	☐
Learning Difficulties	☐	Cystitis	☐	Cramps in toes or feet	☐
ADHD / ADD	☐	Thrush	☐	Muscular Aches	☐
Hyperactivity	☐	PMS – Mood swings	☐	Eye Disorders	☐
Autism	☐	PMS - Pain	☐	Mouth Ulcers	☐
Epilepsy	☐	Asthma	☐	Indigestion/ Heartburn	☐
Anxiety	☐	Bronchitis	☐	Nausea	☐

Depression	☐	Breathlessness	☐	Constipation	☐
Irritability	☐	Sinusitis	☐	Diarrhea	☐
Insomnia	☐	Colds	☐	Flatulence	☐
Fatigue	☐	Tonsillitis / Sore throats	☐	Abdominal Bloating	☐
Dizziness	☐	Cough	☐	Excessive Appetite	☐
Pins and needles	☐	Sneezing	☐	Poor Appetite	☐
Numbness	☐	Rhinitis	☐	Acne	☐
Chest Pains	☐	Seasonal allergies	☐	Eczema	☐
Palpitations	☐	Catarrh	☐	Hives	☐
Low Blood pressure	☐	Osteoporosis	☐	Excessive Perspiration	☐
High Blood pressure	☐	Arthritis	☐	Blistering	☐
Swelling / Edema	☐	Swollen joints	☐	Dry Skin	☐
Diabetes	☐	Joint Pain	☐	Rashes	☐
ME / Chronic Fatigue	☐	Shoulder tension	☐	Other Skin Problems	☐

Anything else we should know?_____
_____

Informed Consent

I understand that Sue Taylor does not claim to diagnose or cure any illness or disease.

I further understand that Sue Taylor primarily uses Muscle response testing (also known as Applied Kinesiology, Autonomic Response Testing) to detect the client's allergies, sensitivities and intolerances, nutritional deficiencies, emotional and structural imbalances and any infections. She then applies the principles of acupressure and energy medicine to bring about desensitization to the allergens detected to reduce and eliminate any future inappropriate reactions when contacting these allergens.

I understand that I am to continue all medications and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them.

I agree that if I experience a life-threatening allergic reaction from any source at any time following a treatment session I will seek emergency help immediately from a physician qualified in emergency treatments, or by calling 911 or attending an emergency room at the local hospital.

I understand that it may be necessary to perform more than one treatment in order to completely desensitise an allergen and that until such time as it is desensitised I may still experience adverse reactions of unknown severity when contacting that allergen.

I understand that it is advisable to return to Sue Taylor to determine if the treated allergens have been completely desensitised.

I have read or have had read to me the above statements and have had opportunity to ask questions about its content and by signing below I voluntarily consent to the diagnostic and therapeutic procedures mentioned above. I intend this consent to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue my participation in these procedures at any time.

Patient Name _____ Guardian Name: _____

Patient / Guardian Signature_____ Date: _____

356 MacLaren St, Ottawa, Ontario, K2P 0M6
Phone: (613) 230 0998 www.ottawaholisticwellness.ca