



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 acupuncture 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 desensitize an allergen and that until such time as it is desensitized 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 desensitized.

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: _____