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).

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What do you do for exercise, recreation and relaxation?

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

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

Symptom	now	past	**Symptom**	now	past	**Symptom**	now	past
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		

What specialist(s) have you seen? ____

List all medications you are currently taking: ____
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List any accidents, injuries, operations and major illnesses you have had:
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List any allergens to which you have **SEVERE** reactions(e.g unable to breathe, swelling), and the symptoms they cause:
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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: ______________________________