Primary Allergy Clinic

1650 38th St., Suite 205 W
Boulder, CO 80301
mountainacupunctureclinic.com
720-201-3817

Tyler A. Stroebel, L.Ac, Certified in Primary Allergy Correction

Length of Appointment – 1 ½ - 2 hours

Allergy Questionnaire

Name:	Date:
Address:	Phone: Home: Cell: Work:
Occupation:	Age:
Email:	DOB:
Referred by:	Emergency contact and number:

1. Instructions: Please answer the questions as they relate to the person being evaluated. A complete and accurate record is important in learning about your allergy problems. **Complete and return by email or bring to 1st appointment. If emailing add name to the document – your name.doc**

Briefly describe the reason for your allergy visit and what you hope to accomplish.

2. Problems: Have you ever had the following conditions?

Yes	No	Check all items	Age of onset	Mild	Moderate	Severe	Explain
		Asthma (wheezing)					
		Breathing problems (SOB, cough)					
		Sinus Troubles					
		Hey Fever (runny/stuffy/itchy nose sneezing)					

		Hives					
		Swelling					
		Eczema or other rashes					
		Recurrent/Frequent Infections (sinus, ear)					
		Reactions to food					
		Reaction to Drugs					
		Reaction to Insects					
		Other					

3. Symptoms: Have you ever had any of the following? If not, leave blank

	How many days last month?	Mild	Moderate	Severe	Circle/highlight the most severe months
Runny or stuffy nose					J F M A M J J A S O N D
Itchy nose or ears					J F M A M J J A S O N D
Sneezing					J F M A M J J A S O N D
Sinus Pressure					J F M A M J J A S O N D
Headache					J F M A M J J A S O N D
Eyes: Red Watery Itchy					J F M A M J J A S O N D
Wheezing					J F M A M J J A S O N D
Coughing					J F M A M J J A S O N D
Wheezing or coughing with exercise					J F M A M J J A S O N D
Skin Problems					J F M A M J J A S O N D
Symptoms worse in:					J F M A M J J A S O N D
Other					J F M A M J J A S O N D

4. Medications: List all medications you are now taking.

Present medication for allergies	How often?
Medication taken in the past for allergies	When?
Present Medications/ Supplements for other reasons	Reason?

Are you allergic to any medications? YES NO Please name:

5. Previous Allergy Evaluation & Therapy

Have you ever had Allergy Skin Tests? YES NO When? RAST Testing? YES NO When?

Have you ever had a severe allergic reaction requiring a doctor's visit? YES NO Substance:

Hospitalization? YES NO Substance: Use of Epipen? YES NO

Please list the results of testing: (If possible provide copies)

Have you ever received allergy injections? YES NO If yes: List for which allergens and dates

6. Precipitating Factors (Triggers)						
Check each symptom box which applies when you are exposed to the following:	Asthma	Nose, Ears Eyes Throat	Headaches	Eczema	Hives	Other
A. Environmental						
1. Dust: Sweeping, Vacuuming, making beds or any other dust exposure						
2. Molds: mildewed areas, raking leaves, swamp coolers, cheeses, penicillin, yeasts						
3. Animals						
4. Outdoor exposure: Seasonal allergens, herbicides, pesticides						
B. Weather and Environmental Changes						
1. High Winds						
2. Humidity						
3. Cold dry air						
4. Air conditioning/heating						
5. Altitude						
6. Motion sickness						
7. Sensitivity to light						
C. Respiratory infections/Colds						
D. Physical Exertion						
E. Irritants: Tobacco, Strong odors, cleaning agents, chemicals, pain						
F. Pollutants Fuel, Pollution/Smog, sulfur dioxide, jet fuel						
G. Foods: Additives, colors, preservatives, sulfites salycilates. MSG						
H. Emotional Expressions: Anger, laughter, crying						
I. Stress						
J. Hormonal factors 1. Menses 2. Other						
K. Medication 1. Aspirin or NSAID's 2. Other						

L. Other Triggers Not listed:						

7. Review of Systems:

General Health	Excellent Good Fair Poor
Full Body	Fever Chills Fatigue Weakness Night Sweats Other:
Head	Headaches Migraines Trauma Sinus Pressure Other:
Eyes	Itching Tearing Swelling Discharge Redness Cataracts Glaucoma Vision Problems Pain Other:
Ears	Infection Pain Itchy Hearing Problems Discharge Tinnitus Vertigo Other:
Nose	Obstruction Drainage Post Nasal Drip Bleeding Dryness Frequent colds Problems with smell Sinus Infection Sneezing Itchy Polyps Snore Other:
Mouth/Throat	Itching Changes in Taste Mouth sores Sore Throat Hoarseness Tonsillitis Age Removed: Other:
Skin	Itching Dryness Rashes Hives Eczema Swelling Seborrhea Infections Other:
Lungs	Chronic Cough Chest Tightness Wheeze Shortness of breath Pain Sputum color: Other:
Chronic/reoccurring infections	Colds Sinus Ears Bronchitis Pneumonia Diarrhea
Heart	Palpitations Pain High/Low Blood Pressure Extremity Swelling Arrhythmias Murmurs Other:
Urinary/ GU	Burning Pain Frequency STD: Other
Hormonal	Thyroid Diabetes Adrenal Female Male Other:
Blood	Anemia Transfusions Lymph node enlargement HIV Other:
Bones, Joints, Muscles	Pain: Swelling: Deformity:
Neuro/Psychological	Syncope Seizures Gait problems Coordination Problems Paralysis Weakness Speech Problems Depression Anxiety Other:
Gastrointestinal	Nausea Vomiting Diarrhea Constipation Gas Regurgitation Pain Bloating Ulcers Blood in stools Other:

8. Past Medical History

Please list other illnesses and medical conditions you have:

List major hospitalizations and surgeries:

9. Family History

Do any members of your immediate family have a history of:

	YES	NO	If yes, Who in family and What substance, trigger, or problem
Allergies			
Hay fever			
Eczema			

Hives	
Frequent pneumonia, sinus or ear infections	
Headaches/migraines	
Other Allergies:	
Other skin issues:	
Lung Disease	
Thyroid issues	
Adrenal issues	
Diabetes	
Cardiac Disease	
Gastrointestinal problems	
Urinary Problems	
Hormonal issues	
Reproductive issues	
Neurological issues	
Psychological issues	
Cancer	
Other disease or issues:	

10. Environmental Survey (Circle or highlight)			
Where do you live? Rural City	Age of your house?	House Construction: (Wood, brick etc)	Type of heating: Forced Air Steam Electric Space Heater Baseboard Other:
Type of cooling system: Central Air Conditioning Window Air Conditioning Swamp Cooler Fans	Do you have an: Air Cleaner? Central Window unit Humidifier? Central Window Unit Floor unit	Are your rooms damp or musty? YES NO If yes, which ones	How many indoor plants do you have and what kinds?
Types of Carpet: Wool Synthetic Jute Other: Wall to Wall? YES NO Is entire house carpeted? YES NO List all room where carpeting is located with type:			
Do you have any stuffed/soft upholstered furniture? YES NO What type of pillows do you use? Do you have feather Comforters? YES NO Do you wear down jackets or clothing? YES NO Does any type of clothing irritate your skin? YES NO If yes, What are they made of?			
Is you mattress: Foam Rubber Innerspring and Cotton Cotton Waterbed Pillow top Other: How old is your mattress? Is it encased in Plastic? YES NO Do you have a mattress cover? YES NO If yes, what is it made of: What type of sheets do you use? How often do you vacuum and turn you mattress? Never Rarely On Occasion Frequently			
What types of grass, shrubs, trees, weeds and flowers grow in the immediate vicinity of your home?			

Do you have pets? YES NO If yes, list number and kind (cat, dog, bird, horse etc)

Does your pet spend time: indoors outdoors Are they allowed in the bedroom? YES NO

11. Social/Occupational History

Please print present occupation followed by past occupations:

Occupation	How long?	Effect of Workplace on symptoms?

Are you exposed to anything at work which might aggravate your condition? YES NO If yes, what are they?

Have you missed any work or school due to your allergies? YES NO If yes, how much time in the last 12 months?

Do you have any other exposure from hobbies or recreational activities? Please list

Tobacco History:
Do you presently smoke? YES NO If yes, how many years? How much per day?
Have you ever smoked? YES NO If yes, when did you stopped?
Does anyone in your home smoke? YES NO If yes, which one(s):
If you still smoke or have a family member who smokes, do you think you/they can stop? YES NO
Would you like information? YES NO

Have you ever used recreational drugs? YES NO If yes, Oral Nasal IV Are you presently using? YES NO
What drugs?

Do you feel that stress/trauma/psychological issues may have played a role in your (child's) allergy problem? YES NO
If yes, how?

Please use this space to provide any additional information that might help evaluating the current problem/condition:

Patient History

Allergy Diagnosis

Name ____________________________ Occupation ____________________________

Address ____________________________ Company ____________________________

City ____________ State ____ Zip ____________ Day Phone ____________________________

Age ______________ Sex ______________ Evening Phone ____________________________

Which of the following symptoms have you experienced? Please circle all that apply.

Hay fever	Asthma	Headache	Eczema
Runny nose	Cough	Diarrhea	Colitis
Stuffy nose	Cough (night only)	Constipation	Sleep problems
Sinus problems	Wheezing	Stomach problems	Mood changes
Sneezing	Shortness of breath	Hives	Fatigue
Itchy eyes	Tight chest	Rashes	Mental dullness
Post nasal drip	Exercise problems	Severe acne	Nausea
Ear problems	Phlegm or mucus	Abdominal cramps	Bloating

How long have you had these symptoms?

0-1 years 1-5 years 5-10 years 10+ years

What time of the year do you have these symptoms?

Jan Feb March April May June July Aug Sept Oct Nov Dec

All the time____________________________ Cannot predict ____________________________

Do you have good months? ______________ If so, which? ____________________________

What else do you know about your allergy symptoms?

Are you aware of anything you *are* allergic to? ____________________________

What do you think you might be allergic to? ____________________________

Are you exposed to chemicals? Dust? ____________________________

Do you have pets / animals? ____________________________

Are you allergic to any medication? ____________________________

Do you smoke? ___________ If yes, how often? ___________ How many years? ___________

Have you ever had allergy tests? _________ If yes: Skin test? _________ Blood Test? ___________

Have you ever had allergy shots? _________ If so, when? ____________________________

Do your symptoms interfere with your:

Sleep? ____ Play? ____ Work? ____ Comfort? ____ Other? ____________________

Are your symptoms worse in the AM or PM? ____________________________

Form courtesy of Hitachi Chemical Diagnostics, Inc.

Mountain Acupuncture Clinic, LLC
1650 38th St, Suite 205W
Boulder CO 80301

WAIVER AND RELEASE

I (Name) ___________________________________, hereby consent to evaluation and desensitization techniques at Mountain Acupuncture Clinic, LLC., 1650 38th St., Suite 205W, Boulder CO 80301.

Mountain Acupuncture Clinic (MAC) and all its employees assume no responsibility for medical conditions requiring attention of a medical doctor. Scope of practice does not allow for recommendation or prescription of medications or treatments during or after the completion of allergy desensitization.

Primary Allergy Correction desensitization techniques are for primary allergies only. PAC does not desensitize allergies that have been known to cause an anaphylaxis reaction.
I agree to fully disclose any life threatening allergies or allergies resulting in anaphylaxis.

- I do not have any life threatening allergies __________(Initial)
- I have life threatening allergies that may cause anaphylaxis __________(Initial)

Substances are ____

I understand:

- ✓ The unpredictable nature of allergies and related symptoms and that PAC can not guarantee any results.
- ✓ PAC can not guarantee that new allergies will not develop in the future.
- ✓ While PAC can treat most allergies, some cases do not respond to the remedies. Referral to other practitioners may be required.
- ✓ The only risk factor, although rare, with allergy desensitization is the possibility of increased sensitivity.
    - I assume all responsibility for unpredictable immune reactions which may lead to increase symptoms.
    - In this event, I agree to seek immediate medical attention.
- ✓ I agree to pay Primary Allergy Correction the standard fee(s) for any and all treatments administered.

I consent to this agreement:

Signature — Signature of Parent or Legal Guardian

Date: — Date:

Witness Signature: Tyler Stroebel, L.Ac

MOUNTAIN ACUPUNCTURE CLINIC DISCLOSURE STATEMENT

Education and Experience

Tyler Abby Stroebel earned her Masters of Acupuncture and Oriental Medicine degree from Emperor's College of Traditional Oriental Medicine in California, December 26, 2001. This four- year program consisted of 3,050 hours of education including 1,000 hours of clinical practice. The National Certification Commission certified her as a Diplomate in Acupuncture and Traditional Chinese Medicine for Acupuncture and Oriental Medicine (NCCAOM) in November 2001. This includes certification in Clean Needle Technique. She was licensed in the state of California to practice acupuncture and Chinese herbology on June 24, 2002. Most recently, March of 2009 Tyler was certified in Primary Allergy Correction.

Tyler's training includes adjunctive therapies such as herbal medicine, moxibustion, tui na, acupressure, cupping, bloodletting, gwa sha, auriculotherapy, and dietary and lifestyle recommendations.

Tyler is a member of the Acupuncture Association of Colorado. She is a registered acupuncturist in Colorado and a licensed acupuncturist in California. None of these licenses, certificates, or registrations has ever been suspended or revoked.

Practices

This treatment room complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning sterilization of needles and sanitation of the room. Only single-use, disposable, factory-sterilized needles are utilized.

Acupuncture/Allergy Treatments

Adult Visit	$100.00
Child Visit (0-10)	$60.00
Moxa or Cupping Treatment Alone	$35.00

Pre-payment Packages (applicable for both acupuncture and allergy treatments):

7 Treatment Package ($5 off each treatment-never expires)-$665.00
10 Treatment Package ($10 off each treatment-never expires)-$900.00
Kid Package (7 treatments) ($5 off each treatment-never expires)-$385

Cancellation Policy:

Please cancel your appointment 24 hours in advance to avoid being charged for that time.

Patients Rights

- The patient is entitled to receive information about the methods of therapy, the techniques, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The Director of Registrations, Colorado, Department of Regulatory Agencies, regulates the practice of acupuncture. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite1340, Denver, Colorado 80202. Telephone (303) 894-7851.

Consent

I give my consent to receive treatment at Mountain Acupuncture Clinic LLC. I understand that payment is due at the time that services are rendered. I understand I may be charged for any appointments I miss if I do not give 24 hours cancellation notice. I have been informed of the policies by which my information is used and transmitted.

I have read and understand this document.

__________________________ __________________________

Patient's Signature Date

Tyler Abby Stroebel L.Ac, NCCAOM, M.T.O.M.
1650 38th St., Suite 205W Boulder, CO 80301 Tel: (720) 201-3817
appt@mountainacupunctureclinic.com

NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Mountain Acupuncture Clinic LLC uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that your receive.

Mountain Acupuncture Clinic LLC will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Mountain Acupuncture Clinic LLC may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Mountain Acupuncture Clinic LLC may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. You have a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer Diva Olvera and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Mountain Acupuncture Clinic LLC must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints please contact Diva Olvera at 720-201-3817.

______________________________	______________
Patient Signature	Date