



BAX AURA INTAKE QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Date of Birth: _____ **ID #** _____

Address: _____

Home#: _____ **Work#:** _____

Gender (circle one): **MALE** **FEMALE**

Medical 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 diseases.*
- *Allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We identify substances that may cause stress on the body and work to reduce substance specific stress using a combination of Low Level Light Therapy, Accupoint Stimulation, Homeopathy, Nutrition and Energetic Information to help bring the body back into balance.*
- *We do not use drugs in this program.*
- *There is no single method that will work for everyone but this integrative approach can help increase your core level energy, boost your immune system and help your body better deal with substance stressors leading to a higher quality of life.*
- *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: _____

MEDICAL HISTORY REVIEW:

Do you have problems with a heart valve, heart murmur, or congenital heart disease? Yes No

If yes, please explain:



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? _____

Do you have an illness that affects your immune system? (Common Variable Immunodeficiency, HIV/AIDS, other Immunodeficiency) Yes No If yes, please specify: _____

Do you have an autoimmune disease? (Lupus, Rheumatoid Arthritis, Sarcoid, Scleroderma, etc.) Yes No If yes, please specify: _____

Do you have cancer? (Lymphoma, Leukemia, Multiple Myeloma, other) Yes No If yes, please specify: _____

Have you ever had a bone marrow or solid organ transplant? (Lung, Kidney, Liver) Yes No If yes, please specify: _____

Do you have problems with your spleen, lack of spleen or sickle cell anemia? Yes No If yes, please specify: _____

Do you have chronic back pain, problems with your discs, sciatica or carpal tunnel? Yes No If yes, please specify: _____

Do you have recurrent or chronic problems with any of the following?

(please check those that apply)

- Checkboxes for various medical conditions: Frequent Headaches, Vision Disturbance/Cataracts, Wear Glasses, Wear Contacts/Soft/Gas Perm, Frequent Colds, Diabetes, Anemia/Blood Disorder, Gynecologic Problems, Asthma, Migraines, Peptic Ulcer, Depression, Chest Pain, Pneumonia, High Blood Pressure, Rapid Heart Beat, Nausea/Vomiting, Kidney/Bladder Disease, Liver Disease/Hepatitis, Glaucoma, Osteoporosis, Anxiety, Loss of Hearing, Heartburn/Reflux, Constipation, Diarrhea, Frequent/Painful Urination, Arthritis, Cancer, Heart Problems/Murmur, Hay Fever, Seizures, Thyroid Disease, Emphysema.

Briefly explain any other chronic symptoms: _____

AGE WHEN ISSUES WERE FIRST OBSERVED

- Infant (Age 0 – 2)
- Child (Age 3 – 5)
- Child (Age 6 – 12)
- Adolescent (Age 13 – 18)
- Adult (Age 19 – 25)
- Adult (Age 26 – 40)
- Adult (Age 40)

FAMILY MEMBERS WITH DIAGNOSED ALLERGIES

- Mother
- Father
- Brother/Sister
- Grandparents
- Son/Daughter
- Spouse
- None

DO YOU, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?

SKIN

- Hives
- Rashes
- Itching
- Eczema
- Swelling
- Sores
- Once had rashes in the bends of knees or elbows
- Above are worse during known pollen seasons
- Above are worse with animal exposure
- Skin problems are rare
- Skin problems are chronic
- None

EYE

- Itching
- Excessive Watering
- Redness
- Swelling
- Above are worse during pollen seasons
- Above are worse with animal exposure
- Tobacco smoke/chemical exposure makes me feel worse
- None

EAR

- Itching
- Blocking, Fullness or Popping
- Pain
- Frequent Ear Infections
- Hearing Loss
- Ear Tubes
- Ringing In Ears

PREVIOUS DIAGNOSIS OF ALLERGY

- Yes, and allergy shots helped.
- Yes, but allergy shots did not help
- Yes, and medication helped
- Yes, but medication did not help
- None

NASAL

- Itching
- Sneezing
- Running Nose-Clear Discharge
- Frequent Nose Blowing
- Above are worse during pollen exposure
- Above are worse with animal exposure
- Runny Nose – Cloudy Discharge
- Stuffiness
- Post Nasal Drip
- Frequent sinus Infections
- Nasal Obstruction
- Loss of Smell

THROAT & MOUTH

- Itching of Throat or Mouth
- Frequent Sore Throat
- Frequent Laryngitis
- Frequent Tonsillitis
- Mouth Sores
- Swelling of the Tongue or Mouth
- None

CHRONIC GASTROINTESTINAL

- Nausea and Vomiting
- Diarrhea
- Gas, Heartburn
- Cramps or Bloating
- Abdominal Pain
- Re-taste Foods
- None

DIGESTIVE TRACT

- Nausea & Vomiting
- Diarrhea
- Constipation
- Bloating Feeling
- Stomach pains or Cramps
- Heart Burn

EMOTIONS

- Mood Swings
- Anxiety/Fear/Nervousness
- Anger/Irritability/Aggressiveness
- Argumentative
- Depressed

TOXICITY

- Frequent Headaches
- Skin Issues
- Constipation
- Foggy Thinking
- Dark Yellow or Orange Urine

HOST (parasite)

- Itchy Ears, Nose, Anus
- Bloating, Gas, Digestive Problems
- TMJ and/or Grind Teeth
- Constipation or Diarrhea
- Low Energy/Low Stamina
- Joint & Muscle Pains
- Depressed

BONE & JOINT

- Joint or Bone Pain
- Muscle Pain
- Redness or Swelling of Joints
- Joint Stiff, Limited Motion

LUNGS

- Chest Congestion
- Asthma/bronchitis
- Shortness of Breath
- Difficulty Breathing
- Persistent Cough
- Wheezing

HEART

- Irregular/Skipped Heartbeat
- Rapid /Pounding Heartbeat
- Chest Pain
- High Blood Pressure

WEIGHT

- Binge eating/drinking
- Excessive Weight
- Compulsive Eating
- Craving Certain Foods
- Water Retention
- Want To Lose 10 lbs +
- Cannot Lose weight no matter what I eat or do

ADRENAL

- Crave Salty, Fatty, High Protein foods
- Get Dizzy when Stand Up Quickly
- I am Tired when I Awake in Morning
- Frequent Sore Throat &/or Laryngitis
- Reduced Sex Drive
- Feeling Overwhelmed, Depressed
- Irregular Sleep/Insomnia

OTHER

- ADD/ADHD
- Autism/Aspergers
- Auto Immune _____
- Chronic Fatigue/ Fibromyalgia
- Multiple Chemical Sensitivity
- Severe Depression
- Obsessive Compulsive Disorder.

HORMONE

- Fatigue
- Sleep issues/Insomnia
- Poor Memory
- Joint/muscle Pain
- Weight Gain
- Low Thyroid function
- Allergies
- Foggy Thinking

CHEST SYMPTOMS

- Tightness
- Asthma or Wheezing with exercise
- Asthma or Wheezing when around animals
- Asthma or Wheezing during pollen seasons
- Asthma or Wheeze around tobacco smoke or chemicals
- Shortness of Breath
- Dry Coughing
- Wet Coughing
- Emphysema
- Frequent Bronchitis
- Recurring Pneumonia
- Chest Pain
- None

I FEEL WORSE

- Outdoors, and better indoors
- 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

THYROID

- Weight gain/ Unable to lose weight with diet/exercise
- Fatigued, exhausted
- I feel Depressed, no motivation, moody
- Dry Skin
- Constipation
- Lost outer edge of Eye Brow
- Hair is Course, dry, brittle, falling out

DEHYDRATION

- Dark Urine or Little Urination
- Walk on outside edge of feet
- Foggy Thinking or light headedness
- Dry Mouth, Dry Skin
- Muscle Cramps
- Ankle swelling

FREQUENCY & SEVERITY OF SYMPTOMS

- Constant, Chronic with Little Change
- Present Most of the Time
- Present Part of the Time
- Present Rarely
- No Interference with Normal Life
- Slight Interference with Normal Life
- Considerable Interference with Normal Life
- Prevents Some Normal Activities

I FEEL BETTER

- After Shower or Bath
- In Air Conditioning
- Indoors
- During or After Physical Activitiy
- After Taking Antihistamines
- With Allergy Shots
- When Away from Home
- When At Home

I FEEL WORSE

- 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
- Don't know

I FEEL BETTER

- When I go out of Town
- When not at Work
- When at Home
- When away from Home
- Don't Know

I FEEL WORSE:

Year Round

- | | | |
|---|-----------------------------------|------------------------------------|
| <input type="checkbox"/> January | <input type="checkbox"/> February | <input type="checkbox"/> March |
| <input type="checkbox"/> April | <input type="checkbox"/> May | <input type="checkbox"/> June |
| <input type="checkbox"/> July | <input type="checkbox"/> August | <input type="checkbox"/> September |
| <input type="checkbox"/> October | <input type="checkbox"/> November | <input type="checkbox"/> December |
| <input type="checkbox"/> no specific time of year | | |

I REACT WHEN IN PROXIMITY OR DURING EXPOSURE TO:

- | | |
|--|--|
| <input type="checkbox"/> Dogs | <input type="checkbox"/> Rabbits |
| <input type="checkbox"/> Cats | <input type="checkbox"/> Birds or Feathers |
| <input type="checkbox"/> Horses or Cattle | <input type="checkbox"/> Bees |
| <input type="checkbox"/> Rodents (mice, guinea pigs, etc.) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> None | |

CHEMICALS I'M SENSITIVE TO:

- | | |
|---|--|
| <input type="checkbox"/> Insecticides & Pesticides | <input type="checkbox"/> Laundry Detergent |
| <input type="checkbox"/> Paints & Household Cleaners | <input type="checkbox"/> Newsprint |
| <input type="checkbox"/> Perfumes & Cosmetics | <input type="checkbox"/> Stove or Furnace Emissions |
| <input type="checkbox"/> Gasoline or Automobile Exhaust | <input type="checkbox"/> Smell of New Fabrics or Fabric Stores |
| <input type="checkbox"/> Chemicals in the Workplace | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> None | |

FOOD RELATED

- | | |
|---|---|
| <input type="checkbox"/> Discomfort occurs 5 – 60 minutes after meals | <input type="checkbox"/> Some foods are craved or addictive |
| <input type="checkbox"/> Some foods cause nasal reactions | <input type="checkbox"/> Some foods cause rashes or hives |
| <input type="checkbox"/> Some foods cause headaches | <input type="checkbox"/> Some foods cause swelling of mouth or tongue |
| <input type="checkbox"/> Some foods cause diarrhea | <input type="checkbox"/> Some foods cause upset stomach or vomiting |
| <input type="checkbox"/> The smell or odor of some foods increases discomfort | |
| <input type="checkbox"/> Preservatives, additives or food colorings increase discomfort | |
| <input type="checkbox"/> Some foods cause tightness in chest, wheezing, difficulty breathing etc. | |
| <input type="checkbox"/> Discomfort occurs with restaurant salad bars or Asian foods | |
| <input type="checkbox"/> Discomfort occurs with any regularly eaten food | |
| <input type="checkbox"/> None | |



Have you had your tonsils and/or adenoids removed? Yes No

Have you had ear, nose or sinus surgery? Yes No

If yes, please explain: _____

What is your current weight? _____ What was your weight 1 year ago? _____

When was your last chest x-ray? _____ Results? _____

Have you ever had sinus x-rays? Yes No If yes, please explain: _____

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.)
Medications that effect the immune system (Prednisone, Imuran, Methotrexate, Cellcept, Cytoxan, Cyclosporine, Tacrolimus)
Chemotherapy

Please list any other medications you are currently taking: _____

SOCIAL:

Where were you born? _____ Where were you raised? _____

Where have you lived? _____

Check which one applies: Single Married Divorced Widowed

How many children do you have? _____ What are their ages? _____

Do you exercise? Yes No If yes, how often? _____/week

How long? _____/workout

Do you drink alcohol? Yes No If yes, how often? _____times/week

How much? _____drinks/day

SMOKING:

Do you presently smoke? Yes No If yes, average number of cigarettes per day: _____

If yes, at what age did you start? _____

Have you ever smoked? Yes No If yes, how many years? _____ When did you quit? _____

Average number of cigarettes you smoked per day: _____

Does anyone smoke in your home? Yes No

Do you want to quit smoking? Yes No If Yes, why? _____

PREVIOUS ALLERGY DIAGNOSIS:

Have you ever seen an allergist? Yes No If yes, allergist's name: _____

Have you had allergy skin testing? Yes No If yes, Date: _____

Did you have any positive reactions? Yes No If yes, please list positive allergens (include any medications):

Have you ever received allergy injections? Yes No

If yes, did your symptoms improve while receiving injections? Yes No

Have you ever experienced an adverse reaction to an allergy injection? Yes No If yes, please explain:

Have you ever received Cortisone? (Prednisone, Methylprednisolone, etc.) drugs? Yes No

If yes, how long ago? _____ How much? _____

ENVIRONMENTAL SURVEY:

Do your discomforts disturb your sleep? Yes No

Do you feel better when away from home? Yes No

How long have you lived in your house/apartment/condo? _____

Do you live in a: House Apartment Duplex Condominium Townhouse

Approximately how many years old is your house/apartment/condo? _____

Do you live in : The City The Suburbs Rural Area

Do you have a basement? Yes No Is your house built on a slab? Yes No

Type of heating system: Hot Air Steam (radiator) Electric Hot Water

Do you have: Wood/Coal Stove Humidifier Dehumidifier Air Cleaner

PETS: (This section only for those who own any pets) How many of the following pets do you own?

Cats _____ Dogs _____ Birds _____ Other _____

Are they indoor or outdoor pets? _____ Sensitive reaction to Animals Yes No



JOHNSON CHIROPRACTIC CLINIC
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SCHOOL HISTORY:

Do you attend school? Yes No If yes, at what grade level?
Is your classroom: Carpeted Tile Other Are there any animals in your classroom? Yes No
Have you missed school due to reactions or sensitivities? Yes No
If yes, how many days did you miss last year due to reactions/sensitivities?

WORK ENVIRONMENT:

What is your occupation? Where are you employed?
How long have you worked there? Is your workplace: Carpeted Tile Other
Is there air conditioning? Yes No Is smoking permitted? Yes No
Are you exposed to chemicals or strong odors? Yes No If yes, briefly explain:
Do you feel worse while at work? Yes No If yes, briefly explain:
Have you missed time from work due to reactions or sensitivities? Yes No
If yes, how much time have you missed in the past year?

Mark The Ones That Apply to You:

COLD SYNDROME

- Aversion to cold and preference for warmth
Tastelessness in the mouth
Absence of thirst; pallor & Cold extremities
Clear and profuse urine
Loose stool
Pale tongue proper with a white slippery coating
Slow pulse

HOT SYNDROME

- Feverish and preference for cooling
Preference for cold
Flushed cheeks and redness of the eyes
Yellowish and scanty urine
Constipation
Red tongue proper with a dry yellowish coating
Rapid pulse

Do you have any surgical scars? Where? For females....have you had an episiotomy or needed stitching after childbirth?



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ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW? _____

IF THE PATIENT IS A CHILD, PLEASE COMPLETE THE FOLLOWING:

Place of Birth: _____ Mother's Age at Birth: _____

Was Pregnancy/Labor/Delivery Normal? Yes No If no, please explain: _____

Birth Weight: _____ Formula or Breast Fed? _____ Well Tolerated? _____

Has child reached normal growth milestones? Yes No If no, please explain: _____

Your relationship to child: _____