

PATIENT INFORMATION

Last Name _____ First Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Telephone Home _____ Work _____ Cell _____

Email Address _____

Age _____ DOB _____ Occupation _____

Who to reach in case of an emergency _____

How did you hear about our clinic? _____

Are you currently receiving health care? Please circle: Y N

If yes, name of physician _____

Conditions being treated _____

Have you or are you receiving allergy immunotherapy (allergy shots)? _____ Yes _____ No

What are your most important health concerns?

1 _____

2 _____

3 _____

Please list tested or suspected **allergies** and related symptoms (Please bring any relevant laboratory results with you on your first visit:

Foods _____

Seasonal / Environmental _____

Pets / Drug / other _____

Current Medications: Please list any prescription medications, over-the-counter medications, supplements or herbs you are taking and for how long.

Do you have a current medical condition(s) (e.g. Epilepsy, Pregnancy)? _____

Do you smoke? Please circle: Y N Do you have pets? Please circle: Y N

Please read the New Patient Information form and the Waiver and Release Form. Sign below when you have finished. *Yes, I have read and understand the items listed on the New Patient Information form, the Office Policies form and the Waiver and Release form.*

Signature _____ **Date** _____

(If under the age of 18, must be signed by Parent or Legal Guardian.)

Waiver and Release

I _____ (the "Undersigned"), consent to treatment at Advanced Allergy Relief of Connecticut.

I understand that treatment procedures are non-invasive and are not considered a medical treatment.

The Clinic and all of its employees assume no responsibility for medical conditions requiring the attention of a medical doctor, or necessary adjustments to prescribed medications during or after the completion of treatments.

I understand the unpredictable nature of allergies and related symptoms and that the clinic cannot guarantee any results. AAT also cannot guarantee that new allergies will not develop in the future. While AAT can treat most forms of allergies, some cases do not respond to the treatment.

I also understand that the only known risk factor with allergy desensitization, (including medical immunotherapy or AAT) is the possibility of increased sensitivity. I assume all responsibility for unpredictable immune reactions which may lead to increased symptoms. In this event, I agree to seek immediate medical attention.

I understand that the Clinic does not treat cases of anaphylaxis and I agree to fully disclose all information regarding any life-threatening allergies or allergies resulting in anaphylaxis.

_____ I do not have any allergies which cause life threatening reactions

_____ Yes, I DO have allergies which cause anaphylaxis. Please explain.

Signed _____ Date _____

If under 18, signature of Parent or Guardian _____

Witness _____ Date _____

Office Policy

Thank you for choosing naturopathic medicine and this office for your health care needs. We hope your time with us is all you wish it to be. We encourage comments, questions, and suggestions. Your health and well being are our prime considerations.

- **Office Hours**

Office hours are Tuesday, Wednesday, Thursday and Friday.

- **Cancellation Policy**

Your appointment time is reserved for you so please notify us if you can't come.

We try to remind you by phone before your appointment. If you do not want us to call or leave a message for you please let us know.

We ask for a minimum of 48 hours notice for cancellations so we can give your time to someone else. You may be charged for a missed appointment.

- **Telephone Calls**

The staff is knowledgeable and available to answer most of your questions. If we are busy with patients, the telephone will be answered by an automated system. Leave a message and your call will be returned as soon as possible. If you're ill or in pain, please say so at the time of your call so we can determine if you need to be seen immediately.

- **HIPAA**

This is a very small medical office. Your health care information is confidential and access is limited. We use your health care information about you for diagnosis and treatment, to consult with other health care practitioners when necessary and with your permission, to obtain payment for treatment, for administrative services, and to evaluate the quality of care you receive. We will not disclose health information for other reasons without your signed permission unless it is required by law. You have the right to examine your records and to have copies for a reasonable fee. You may request a change in your records if you believe they are incomplete or incorrect. If you are concerned we have violated your privacy rights you may complain to us or directly to the US Department of Health and Human Services.

We are required by law to protect the privacy of your information and to provide you with this information. More complete rules and regulations are available on request.

I understand my rights under the Health Insurance Portability and Accountability Act of 1996.

Patient Signature _____ Date _____

Information for New Patients

In order to receive the best possible treatment, it is important to read and understand the following information:

- Successful elimination of allergies/sensitivities may require clearing preliminary allergens determined in the initial assessment, such as vitamins and/or minerals. If components of allergens are not cleared, the treatment will not be successful. Because of this important factor, the initial allergens are treated in a specific order. For example, sugar needs to be treated before an allergy to alcohol, grains or fruit. We make every effort to address your primary concerns in the first treatment.
- After any possible preliminary allergies/sensitivities are cleared, you may eliminate any allergy/sensitivity in any order, including remaining food items, inhalants, environmental allergies, contactants, etc.
- It is possible to treat numerous items in one treatment if they are in the same family. For example, all dairy products (milk, cheese and yogurt) and calcium may be treated together. But dairy and wheat, or tomatoes and pollens may not be cleared at the same time. The treatment will not be successful.
- The average allergy/sensitivity typically requires only one treatment, however sometimes more than one treatment is needed for an allergy/sensitivity to clear. Advanced Allergy Therapeutics cannot guarantee that each allergy/sensitivity will only take one treatment.
- When treating a condition (rather than an isolated allergy), multiple items may be contributing. Therefore such conditions may require multiple treatments.

Please adhere to the following guidelines:

- Do not smoke or wear strong perfume 2 hours prior to a treatment. These odors can affect the testing and treatment of yourself and other subsequent patients in the clinic.
- Do not eat candy or chew gum during the treatment.

Initial Allergen Evaluation for _____ Date _____

Today you were treated for _____ Your next treatment will be for _____

Food Phenolics	Sugar Mix	Glutamates	Pollens
Eggs	Salt Mix	Amines	Trees
Chicken	Grain / Wheat Mix	Salicylates	Grasses / Weeds
Protein	Corn	Artificial Preservatives	Flowers
Calcium	Yeast Mix	Artificial Colors	Plants
Milk / Dairy	Caffeine	Artificial Flavors	Plant Phenolics
Vitamin C	Coffee Mix	Tomato	Molds
B-Complex	Chocolate	Potato	Fungus
Vitamin A	Soy	Acids	Dust / Dust Mites
Iron	Mineral Mix	Enzymes Comp	Dogs / Cats