

Welcome to

Vitality Wellness
& ALLERGY RELIEF
www.vitalitychiro.com

(408) 363-1991

David W. Basista, D.C.

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ALLERGY QUESTIONNAIRE

Patient's Name _____ Male Female

Your Name (If other than patient) _____

What do you (patient) prefer to be called? _____ Birthdate ___/___/___

D.L. # _____ State ___ Do you observe birthdays or holidays? Yes No

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Wk # _____ Mobile # _____

Fax # _____ E-Mail Address _____

Employer _____ Occupation _____

Emp. Address _____

City _____ State _____ Zip _____

Your Marital Status: Single Married Divorced Separated Widowed

Spouse's Name _____ Names/Ages Children _____

Primary Care Physician: _____

Referring Physician: _____

Although your history and symptoms are very important in our analysis of your condition, it is also important that you understand:

- ☺ Allergies are an inappropriate response by one's immune system to an otherwise harmless substance.
- ☺ We do not use drugs or shots in this program.
- ☺ We do not treat symptoms or diseases.
- ☺ Our procedures are safe and painless.

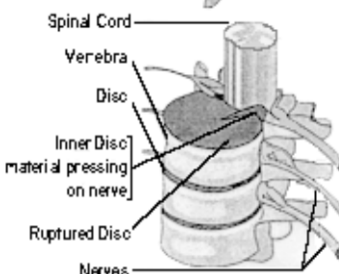
Please answer the questions on this form as they relate to the person being evaluated.

Briefly describe the reason for your visit and what you hope to accomplish: _____

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your current health condition. In other words, tell us how much your condition is preventing you from doing what you would normally do, or from doing it as well or enjoying it as much as you otherwise would. PLEASE CIRCLE THE NUMBER (0-10) THAT BEST DESCRIBES YOUR LEVEL DISCOMFORT OR YOUR ABILITY TO FUNCTION IN YOUR DAY TO DAY LIFE.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function Totally unable to function



Medical History/Symptoms review:

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

If yes, please explain: _____

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

Do you have an autoimmune disease? (Lymphoma, Leukemia, Multiple Myeloma, other) 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?

General Health History

- | | | |
|---|--|---|
| <input type="checkbox"/> Severe or Frequent Headache(s) | <input type="checkbox"/> Heart Problems/Murmur | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Krohn’s Disease |
| <input type="checkbox"/> Seizures/Fainting/Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Vision Disturbance/Cataracts | <input type="checkbox"/> Rapid Heart Beat | <input type="checkbox"/> Liver Problems/Hepatitis |
| <input type="checkbox"/> Wear Glasses | <input type="checkbox"/> Asthma/Breathing Difficulties | <input type="checkbox"/> Gynecologic Problems |
| <input type="checkbox"/> Wear Contact/Soft/Gas Perm | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney/Bladder Prob/Bedwet |
| <input type="checkbox"/> Frequent Cold, ____/Year | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Frequent/Painful Urination |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Cancer (Type) _____ |
| <input type="checkbox"/> Anemia/Blood Disorder | <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Weight Problem | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Shingles/Herpes |
| <input type="checkbox"/> Other _____ | | |

If yes to any above, please explain: _____

BEHAVIORAL, POSSIBLY ALLERGY-RELATED, SYMPTOMS/CONDITIONS

- | | |
|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Asperger’s Syndrome |
| <input type="checkbox"/> Learning Disorder | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> OCD | <input type="checkbox"/> Dyslexia |
| <input type="checkbox"/> Other _____ | |

If yes to any above, please explain: _____

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Common Allergy Symptoms

- Skin Problems or Symptoms
- Eye Problems or Symptoms
- Nasal Problems or Symptoms
- Ear Problems or Symptoms
- Other _____
- Chest Problems or Symptoms
- Gastrointestinal Problems or Symptoms
- Bone and Joint Problems or Symptoms
- Throat & Mouth Problems or Symptoms

If yes to any above, please explain: _____

AGE WHEN SYMPTOMS WERE FIRST OBSERVED

- Infant (Age 0 – 2)
- Adolescent (Age 13 – 18)
- Adult (Age 40 +)
- Child (Age 3-5)
- Adult (Age 19-25)
- Child (Age 6-12)
- Adult (Age 26-39)

PREVIOUS ALLERGY EVALUATION:

- Have you ever seen an allergist? Yes No If yes Date: _____
- Have you had allergy skin testing? Yes No If yes, Date: _____
- Did you have any positive reactions? Yes No If yes, please list positives (include any medications): _____

Treatment

- allergy shots helped.
- medication helped
- allergy shots did not help
- medication did not help
- None

FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS

- Constant, Chronic with little change
- Present part of the time
- Slight interference with Normal Life
- Prevents some normal activities
- Present most of the time
- Present Rarely
- Considerable interference with Normal Life
- No interference with Normal Life

SYMPTOMS ARE WORSE

- Outdoors, and better indoors
- During wet or damp weather
- During known pollen seasons
- When exposed to tobacco smoke
- When sweeping or dusting the house
- In fields or in the country
- In the bedroom or when in bed
- When the weather changes
- In certain rooms or buildings
- With yard work, cut grass, leaves, hay or barns
- In areas with mold or mildew
- Don't know
- At nighttime
- During windy weather
- In air conditioning

SYMPTOMS ARE BETTER

- After shower or bath
- During or after physical activity
- Don't know
- In air conditioning
- After taking antihistamines
- Indoors

ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

- Dogs
- Cats
- Rabbits
- Horses or Cattle
- Bees
- Birds or Feathers
- Rodents (mice, guinea pigs, etc.)
- None
- Other _____

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FOOD RELATED SYMPTOMS

- Some foods are craved or addictive
- Some foods cause nasal symptoms
- Some foods cause asthma
- Some foods cause rashes or hives
- Some foods cause headaches
- Some foods cause diarrhea
- Symptoms flare 5-60 minutes after meals
- Some foods cause upset stomach or vomiting
- The smell of odor of some foods increases symptoms
- Preservatives, additives or food coloring increase symptoms
- Some foods cause swelling of mouth or tongue
- Symptoms occur with any regularly eaten food
- Symptoms occur with restaurant salad bars or Asian foods
- None

FOODS THAT CAUSE SYMPTOMS WITHIN 1 – 2 HOURS

- Eggs
- Milk
- Beef
- Corn
- Wheat
- Soybean
- Peanut
- Pork
- Fish
- Shellfish
- Orange or other citrus
- Potato
- Tomato
- Yeast
- Chocolate
- Coffee or Tea
- Other: _____

FOODS THAT CAUSE SYMPTOMS WITHIN 2 – 24 HOURS

- Eggs
- Milk
- Beef
- Corn
- Wheat
- Soybean
- Peanut
- Pork
- Fish
- Shellfish
- Orange or other citrus
- Potato
- Tomato
- Yeast
- Chocolate
- Coffee/ Tea
- Other: _____

CHEMICALS THAT CAUSE SYMPTOMS

- Insecticides & Pesticides
- Paints & Household Cleaners
- Gasoline or Automobile Exhaust
- Perfumes & Cosmetics
- Stove or Furnace Emission
- Chemicals in the workplace
- Laundry Detergent
- Newsprint
- The smell of new fabrics/fabric store
- Other _____
- None

When are your symptoms worse: Year Round

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

Have you had your tonsils 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: etc _____

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,)
Bronchodilators (Albuterol, Ventolin, Proventil, Serevent, or OTC's such as Primatine Mist, etc.)
Steroid Inhalers (Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair, etc.)
Nasal Steroids (Beconase, Flonase, Nasacort, Rhinocort, etd.)
Chemotherapy
Medications that affect the immune system; (Prednisone, Imuran, Methotrexate, Cellcept, Cytoxan, Cyclosporine, Tacrolimus, etc.)
Please list any medications that you are currently taking: _____

SOCIAL:

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

Where have you lived? _____

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

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 that you smoke(d) per day: _____

Does anyone smoke in your home? Yes No

Have you ever had a reaction to X-ray dye? Yes No If yes, please explain: _____

ENVIRONMENTAL SURVEY:

Do your symptoms disturb your sleep? Yes No

Are your symptoms better when away from / or at (Circle one) home? Yes No

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 (baseboard)

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

PETS:

How many of the pets do you own?

Cats _____ Dogs _____ Birds _____ Other _____

Are they indoor or outdoor pets? _____

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 allergies or asthma? Yes No

If yes, how many days did you miss last year because of allergies or asthma? _____

WORK ENVIRONMENT:

What is your occupation? _____

Where are you employed? _____

How long have you worked there? _____

Is you 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: _____

Are your symptoms worse while at work: Yes No If yes, briefly explain: _____

Have you missed time from work due to allergies or asthma: Yes NO

If yes, how much time have you missed in the past year? _____

FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

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

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ADDITIONAL INFORMATION

Please use this page to fill out any additional information that you feel may be pertinent.

Signature _____ Date _____

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 Name _____ Your relationship to child: _____

Guardian's Signature _____ Date _____

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Guidelines to Follow for Optimum Results

The day of your appointment:

If you need to reschedule your appointment, please give us at least 24 hrs notice to avoid a cancellation charge. Following these instructions will help you get the most out of your Allergy Relief Program

Please schedule appointment so that you are not being tested during the first three days of your menstrual cycle.

Please drink a lot of water during the 48-96 hours before your visit. You will need to be well hydrated to receive maximum benefit.

Do not take any supplements or unnecessary medications for at least four hours before your appointment. Also, do not take any aspirin or pain medication for 12 hours before being tested, if possible.

Do not consume alcohol for 12 hours before your appointment.

Do not wear any jewelry (Or be prepared to remove). You may wear your wedding ring.

Do not wear pantyhose or clothes with very tight sleeves (Or be prepared to remove), as they will interfere with the testing procedures. The procedure requires that we have access to the skin over your spine, your elbows, hands and feet (Gowns will be provided.)

Please do not wear perfume, strong smelling deodorant, fragrances, essential oils, **hand lotion**, aftershave or cologne on the day of your visit. (**before or after**).

At the end of your visit you will be given some instructions and a list of foods to avoid for 24 hours.

Please eat before your appointment. You will be asked to not eat for one hour after your visit. So, do not come to the office hungry.

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After you receive a clearing:

You may not shop for eight hours after the visit. So, please shop in advance of your visit.

You may not bathe or shower for eight hours after your clearing, so please shower before your visit.

You may not go to a restaurant for eight hours, for *any* reason!

You may not visit a hair salon, barber shop, or nail salon for twelve hours after your clearing.

You must avoid all chemicals and chemical fumes for twelve hours, so please refuel your automobile before your visit.

You must avoid or severely limit your exposure to EM radiation. This includes, but is not limited to; cell phones, cordless home phones and CRT video monitors.

Please also avoid: *Adjustments, Massage, Acupuncture, Vigorous Exercise, Hot Tub, Sauna, Steam Room or Swimming* for twelve hours after clearing.

You may not consume alcohol for twelve hours after your clearing.

Do not eat anything for 1 hr nor a large meal for at least 4 hrs after your visit.

You will be given a list of additional foods/things to avoid for 24 hours after your reprogramming.

These instructions are based on years of practical experience. You may be able to break some or all of these rules and do just fine, or you may bend one rule and have to repeat the visit. You will have the best chance for success if you follow all these instructions. These restrictions are to be followed for at most 24 hours, a small price to pay for such a long-term benefit!

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