BioReset Health and Wellness

Intake Questionnaire Date: _____

Name: _____ D.O.B. (d/m/y) _____

Phone: (H) _____ (Cell) _____ Email: _____

How were you referred?

- ❑ Physician _____
- ❑ Other _____
- ❑ Self Referral

Are you currently pregnant? ❑ Yes ❑ No

Do you have a pacemaker? ❑ Yes ❑ No

What problem brings you or your child to this appointment (Top 3 Health Concerns)?

_____

_____

_____

When did the symptoms begin? _____

Are your symptoms getting worse? Circle: Yes or No.

Do you have any of the following symptoms? Please check all that apply.

- ❑ Cough
- ❑ Wheezing
- ❑ Shortness of Breath
- ❑ Chest tightness
- ❑ Sneezing
- ❑ Phlegm / Sputum: Color_____
- ❑ Runny Nose
- ❑ Nasal Congestion
- ❑ Itchy Nose
- ❑ Itchy / Watery Eyes
- ❑ Postnasal Drip
- ❑ Nasal Polyps
- ❑ Poor Sense of Smell
- ❑ Ear Infections
- ❑ Sinus Infections
- ❑ Blocked Ears
- ❑ Eczema
- ❑ Hives/Swelling
- ❑ Headaches
- ❑ Snoring
- ❑ Fatigue
- ❑ Other

Which of the following trigger (or cause) the symptoms. Please check all that apply.

- ❑ Grass
- ❑ Hay
- ❑ Mold & Mildew
- ❑ Basements
- ❑ Leaves
- ❑ Cats
- ❑ Latex (rubber)
- ❑ Dogs
- ❑ Horses
- ❑ Other animals
- ❑ Alcoholic Beverages
- ❑ Cosmetics
- ❑ Aerosol sprays
- ❑ Other: _____
- ❑ Perfumes
- ❑ Insecticides
- ❑ Odors
- ❑ Drafts
- ❑ House dust
- ❑ Smoke
- ❑ Pollution
- ❑ Exercise
- ❑ Nervousness
- ❑ Cold Air
- ❑ Humidity
- ❑ Weather Changes

When are your symptoms worse?

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

Are symptoms better away from home? Circle: Yes or No. If yes, when? _____

Occupation (current or previous): _____

Any harmful exposure at work or school? _____

Environmental Survey

How long have you lived in your house/apartment? _____
Approximately how old is your house/apartment/condo? _____

Do you live in a: ❑ House ❑ Apt / Duplex ❑ Condo / Town House
Do you live: ❑ In the city ❑ In the suburbs ❑ Rural areas
Do you have a basement? ❑ Yes ❑ No
Is your bedroom in the basement? ❑ Yes ❑ No
Type of heating system? ❑ Hot Air ❑ Steam (radiator) ❑ Electric ❑ Hot water baseboard
Do you use a: ❑ Humidifier ❑ Wood/Coal Stove ❑ Dehumidifier ❑ Air Cleaner

Of Pets? Indoor or Outdoor? ❑ None ❑ Cats ❑ Dogs ❑ Birds ❑ Other

Do you have allergy proof encasing for pillow or mattress? ❑ Yes ❑ No
What type of pillow do you have? _____
What type of comforter do you have? _____
What type of floor covering do you have in your bedroom? ❑ Carpet/Area rug ❑ Animal skin ❑ Bare floor ❑ Other
If other, please explain _____
How old is your mattress? _____ What is in your mattress? (i.e. cotton, foam, etc.) _____

Do you have air conditioning? ❑ Yes ❑ No If yes, ❑ Window Unit ❑ Central
Do you have water leaks, mold contamination? ❑ Yes ❑ No
Is your home/apartment excessively humid? ❑ Yes ❑ No
Have you had ear, nose or sinus surgery? ❑ Yes ❑ No
If yes, please explain: _____
_____

Are there any tobacco smokers in your house? ❑ Yes ❑ No
Do you smoke now? ❑ Yes ❑ No How Much? _____ # Of years? _____
Have you smoked before? ❑ Yes ❑ No When did you stop? _____ # Of years? _____

Describe any reaction to insect stings: _____

_____

List medications & dosages (including nasal sprays, allergy medications, alternative/herbal products):

_____

_____

_____

Food Stressors Section:

Check any symptoms that you have experienced and list the foods that may have triggered the symptoms:

- ❑ Abdominal cramping _____
- ❑ Anaphylactic shock _____
- ❑ Arthritic type symptoms _____
- ❑ Canker sores _____
- ❑ Celiac's disease _____
- ❑ Constipation _____
- ❑ Depression _____
- ❑ Diarrhea or loose stools _____
- ❑ Difficulty concentrating _____
- ❑ Emotional upset _____
- ❑ Eczema _____
- ❑ Fatigue or sudden drops of energy after meals _____
- ❑ Gas or bloating _____
- ❑ Heartburn or indigestion _____
- ❑ Hives _____
- ❑ Irritable bowel syndrome (IBS) _____
- ❑ Irritability _____
- ❑ Itching – skin or rectal _____
- ❑ Migraine headaches _____
- ❑ Nausea _____
- ❑ Rhinitis _____
- ❑ Runny nose _____
- ❑ Stiffness of joints _____
- ❑ Stomach ache _____
- ❑ Swelling of lips and face _____
- ❑ Swelling of the joints _____
- ❑ Vomiting _____
- ❑ Wheezing _____

Miscellaneous: Indicate any additional information about your symptoms:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Date: _____ Questionaire Reviewed: _____