Elan Family Wellness Centre

A.S.T.T. Allergy Treatment Intake Form

Name:_____ Date:_____

Address:_____ City:_____ Postal Code:_____

e-mail:_____ Home phone:_____

Work phone:_____ Alternate phone:_____

Date of birth:_____ Marital status:_____

Number of children:_____ Occupation:_____

Why are you interested in A.S.T.T. today? _____

_____

How did you hear about us? _____

What known allergies do you have? _____

_____

_____

What allergies/ sensitivities or intolerances do you suspect? _____

_____

When did this complaint begin? _____

When and Where did/do you notice the onset of symptoms? _____

_____

How often does this take place? _____

On a scale of 1 to 10 (10=worst), how would you rate your average symptoms? _____

What makes them better? _____

What makes them worse? _____

What treatment have you sought for this complaint? _____

Is there a family history of allergies? _____

Childhood Illnesses, Trauma, Allergies _____

_____

_____

Adult Illnesses, Trauma (including emotional, mental and chemical)? _____

_____

_____

Past hospitalizations, Surgeries, Injuries _____

_____

_____

Immunizations/ Vaccinations? Are they current? Any adverse reactions? _____

_____

Are you pregnant? Yes/No How far along? _____

Do you eat a healthy diet?_____

Are you taking any medications or drugs? _____
Vitamins/supplements _____

Do you drink alcohol? _____how often_____
Do you take caffeine? _____how often _____

Do you or have you ever smoked? _____ how much _____

What type of exercise do you participate in? Hobbies? _____

_____

What are the major stressors in your life and how do you deal with them? _____

_____

How do you consider your emotional health? _____

Are there any other significant events in your life or family history (including health history) that may have influenced your health? _____

_____

_____

For Patient:

I request and consent to the examination on myself or the patient named below who I am legally responsible for, by Matthew Scott Hutchison, for the purpose of work with A.S.T.T. (Allergy Sensitivity Testing and Treatment). I understand that any findings are not a diagnosis and any recommendations are not to be construed as medical advice. I acknowledge that I will inform him of any allergies that I am aware that I have. I understand that the technique does not guarantee results, although energy balancing of blocked meridians has shown, through multiple case studies, that many allergies can be relieved through this technique. If I have questions, I know that I can expect to have them addressed by Matthew Scott Hutchison. I understand that there may be some risk involved with care-as a reaction to the substance being treated, but that most symptoms are short-lived. I have read this consent and by signing below consent to A.S.T.T. treatment in this clinic.

_____(Signature of Patient or Guardian)

_____ (Date)