

Carol Harris Lipschultz, D.C., D.N.B.H.E.

•
Doctor of Chiropractic
Homeopathy Master Clinician, H.M.C.
1866 Ashland Ave. • Saint Paul, MN 55104
651-644-9691
651-644-3815 (fax)

HOMEOPATHY - GENERAL INFORMATION

WHAT HOMEOPATHY CAN DO FOR YOU

Homeopathy offers you a safe, effective and natural way of healing by activating your body's own natural defenses and releasing your inner power of self healing. By inquiring into the possibility of consulting a professional Homeopathic practitioner, you have already shown that you are interested in a legitimate medical alternative for a specific problem or your overall health care.

A truly healthy person has a natural resistance to disease and symptom development. The immune system is one part of this natural resistance. When any symptoms appear, it is an indication that this naturally strong and complete defense has been, to some extent overcome. True health can be restored only when this inner defense has been repaired and returned to its optimum strength. The body can then once again defend itself against further disease. Homeopathy works naturally, and thoroughly by boosting the immune system.

For many people, it may have been a long time since they actually had a sense of "well-being" and they have forgotten what it feels like to be truly healthy. Homeopathy can restore the vitality, energy, joy of living and happiness that are the natural attributes of a healthy person.

CONDITIONS THAT CAN BE TREATED

A wide variety of physical, emotional and mental ailments have been treated very successfully with Homeopathy. For nearly 200 years this natural system has been used world wide to assist thousands of people in recovering from "chronic" or "incurable" conditions. Such conditions as "Chronic Fatigue Syndrome", migraine headaches, ADD,ADHD, premenstrual syndrome and other menstrual complaints, anxiety, high blood pressure, digestive problems, allergies, asthma, childhood illness including ear infections, skin problems, herpes and many other physical problems have been successfully treated with Homeopathy.

GENERAL INFORMATION

LENGTH OF TREATMENT

The length of treatment depends on many factors and can only be estimated at the conclusion of the initial evaluation. The overall health of the patient, the type of disease conditions present, the amount of conventional or prescription medications that have been or are currently being used are all influential in anticipating the response to treatment. In general, however, it is usually estimated that one month under the influence of a Homeopathic remedy is needed for every year that an illness has been present.

FIRST INTERVIEW

The first evaluation lasts about two hours. During this time an extensive interview is conducted in which the Homeopath gathers detail about your current condition, medical problems, past history, life style, character, how you respond to certain stresses and other relevant information. Much of the information that is useful to a Homeopath is very different from the kind of information that other practitioners use. The general focus of this initial evaluation is to gather enough information to get a clear picture of you as a whole person, including the physical, emotional and stress factors in your life. Once the evaluation has been completed, one specific Homeopathic remedy is prescribed for you. It is chosen specifically to activate healing for the variety of ailments and problems that are discussed in the evaluation.

FOLLOW-UP VISITS

The follow-up evaluation is made one month after the administration of your specific Homeopathic Remedy and lasts approximately one hour. It is necessary to wait a month to allow the healing process to begin. The total number of follow-up visits varies from person-to-person. Monthly updates are not uncommon, as this is often necessary to keep current with a patient's progress. It must be realized that each person is different and the needs of each case are highly individualized. Subsequent appointments are made in accordance with these factors.

THE HEALING PROCESS

Homeopathic remedies can provide thorough, long lasting and complete elimination of many kinds of ailments, both acute and chronic, over time. The process of this kind of healing is different than the process of symptomatic relief or chronic medical treatments. During the first stages of homeopathic treatment, patients will often experience an intensification of their symptoms as well as emotional states. If this does occur, it is usually limited and occurs within the first few weeks of starting the remedy. This reaction is viewed as a very favorable one from the perspective of the overall health of the patient. It indicates that the body is responding to the homeopathic remedy and is working now to

GENERAL INFORMATION

eliminate the disease process that is at the root of all symptoms. This stage is often referred to as the "Homeopathic aggravation" however, a more accurate term would be the "Homeopathic Healing Event."

The idea of having to increase the very symptoms you want to eliminate can be a rather unpleasant thought. This should not frighten you or cause any concern. There is a big difference between a typical aggravation of symptoms and what occurs during the Homeopathic treatment. Here, the symptoms generally are intensified for only a short period of time, occur in a modified form and are accompanied by other signs and indications of healing and improvement from other aspects of the total person.

HOMEOPATHY REMEDY

The homeopathic remedies are made from natural substances such as plants and minerals. There are 2000 different remedies and it is the job of the Homeopath to determine which one is correct for you. The first remedy is provided for you as part of your consultation. Homeopathic remedies are extremely safe, non-toxic, and do not cause allergic reactions.

As a practitioner, I am interested in providing you with the greatest benefit from Homeopathy. It has been my experience that there are occasions when knowing which homeopathic remedy has been prescribed can influence the perception of symptoms by the patient. Often a patient will investigate the way a specific remedy is supposed to effect them and this will in turn make subtle changes in the way they report symptoms to me. Because homeopathy relies on very subtle changes to determine improvements or make the decision to change the remedy, it is vital that all the information collected be spontaneous and unbiased. For these reasons, I reserve the ability to decide when to inform the patient of the specific name of the Homeopathic remedy which I have prescribed. In most cases, once I am certain of the remedy's positive action, its name is given to the patient.

ANTIDOTES

There are certain substances that will interfere with your Homeopathic treatment and they are listed on the Antidote List. It is essential to avoid all the items on the list. They can either completely stop the action of the remedy or delay the healing process. Homeopathy is a complete system which addresses all the ailments a person has a given time in a comprehensive way. Therefore, symptoms which arise seemingly independent of the reason you are receiving Homeopathic treatment, may actually be part of the overall healing process. Self administration of medication for these problems will disrupt treatment. It is important to report "minor" things like colds, flu, back aches, headaches, and other problems to your Homeopath for evaluation rather than treat them yourself as you may have been accustomed to doing.

GENERAL INFORMATION

PATIENT EDUCATION

Homeopathy - Medicine of the New Man, by George Vithaulkas
Everyday Miracles - Homeopathy in Action, by Dr. Linda Johnston, M.D.

OFFICE HOURS

The office hours are 8:30 am to 6:00 pm, Monday - Thursday, and from 8:30 am to 3:30 pm on Friday. For emergencies that occur outside of regular office hours, week-ends or holidays, I am available by calling my office number and leaving a message. Another available option is to call my beeper number and leave a message with the operator. I will return your calls as soon as possible. If your call is not answered within 20 to 30 minutes and you are in a genuine medical emergency, it is the recommendation of this office that you seek emergency medical care.

INSURANCE

Payment for all services is due in full at the time of service. The patient is financially responsible for all charges. At this time insurance does not pay for homeopathic services and/or supplies.

I am available to answer any additional questions you may have about Homeopathy and your care.

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HOMEOPATHY ANTIDOTE LIST

Homeopathic remedies are very powerful medicinal substances. Their action and effectiveness, however, can be disturbed by some of the chemicals and medicines commonly used in our lives. The following is a list of things that should be completely avoided for maximum benefit from your Homeopathic treatment.

If you are taking doctor prescribed medicine, we need to discuss it before starting Homeopathic therapy. If you have a question or concern about medicines during Homeopathy, call before taking anything.

It is not uncommon for Homeopathic remedies to bring back old symptoms. It is essential that these symptoms be allowed to come forward, be recognized and naturally disappear on their own. This may cause temporarily discomfort and/or pain and should be considered part of the "Homeopathic Healing Crisis." Keep this in mind before going to the medicine cabinet and feel free to call about any symptoms or questions regarding medication or symptom relief.

MEDICATIONS

- *No antihistamines, cold medication, cough syrups or cough drops.
- *No antibiotics or antibiotic ointments such as Neosporin.
- *No pain medications, head-ache medicines, Tylenol, Aspirin, Advil or PMS medication.
- *No over the counter, non-prescription medicines or products advertised on TV or in magazines.
- *No skin ointments or topical steroids like Cortisol, poison-ivy medicine, or cremes advertised for itching, rashes or other skin symptoms.
- *No home prescribed or other practitioner prescribed homeopathic treatments.
- *No home herbal therapies without checking with me first.

COFFEE AND TEA

- *No decaffeinated or regular coffee or tea. This includes instant coffee or tea from Chinese/Vietnamese restaurants.
- *No coffee ice-cream, kaluha, coffee candy, coffee yogurt, coffee cookies or any coffee flavored food.

You may have herb teas, or cola drinks not exceeding one can per day. **Cafix with No Coffee** and **Celestial Seasonings Caffeine Free Tea** are good coffee substitutes.

AROMATIC SUBSTANCES

- *No camphor, menthol, eucalyptus, peppermint, spearmint, chocolate mint chips, wintergreen, moth balls or large amount of fresh mint.
- *No lip balms, Carmex or Chapstick because they include menthol or camphor.

HOMEOPATHY ANTIDOTE LIST

- *No cream rinses, bubble bath and sport rubs that contain any of the above, these included: Tiger balm, White Flower Oil, Olbas products, Deep Heat, Vicks Vapor Rub, Ben-Gay, or Noxzema.
- *No after dinner mints or mints candy.
- *No cough drops, throat lozenges and Chinese candies.
- *No mint mouthwashes or toothpaste with extra mint flavoring.

***Check all products for the presence of these substances, including your shaving cream, shampoo, hair rinse, bug repellent and suntan lotion.**

DENTAL WORK, ACUPUNCTURE

- *Dental work will antidote Homeopathic remedies.
- *Routine teeth cleaning will not cause a problem.

Please try to schedule dental work before a Homeopathic remedy is given. If this is not possible, call my office and we will arrange to repeat your remedy.

ELECTRICITY

- *No sleeping under an electric blanket. You can heat the bed, however, the electricity over your body can effect Homeopathy.
- *Water bed heaters and heating pads will not cause problems.
- *Routine dental x-rays and airport security will not interfere with your Homeopath.

OTHER THERAPIES

- *No acupuncture or accupressure treatments.
- *No home or other practitioner prescribed homeopathy.
- *If you are seeing a Chiropractor, please let me know before we begin Homeopathy treatment.

RECREATIONAL DRUGS

- *No marijuana, hashish, cocaine, LSD, mescaline, all others.

Chocolate, alcoholic beverages, cigarettes, and pop of any kind should be avoided because they are detriment to your health. If you do use any of these, talk to me first.

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Registration Information - Adult

Name _____ Birthdate _____ Age _____ Date _____
Home Address _____ Home Phone _____
City _____ State _____ Zip Code _____

Identification

Social Security No. _____ Driver's License No. _____

Employment

Employment school homemaker full time part time unemployed disabled retired
Occupation _____ Employer _____
Business Address _____ Business Phone _____
City _____ State _____ Zip Code _____

Spouse

Spouse's Name _____
Spouse's Employment school homemaker full time part time unemployed disabled retired
Spouse's Occupation _____ Spouse's Employer _____
Business Address _____ Business Phone _____
City _____ State _____ Zip Code _____

Emergency

Person to contact in case of Emergency _____ Relationship _____
Address _____ Phone _____
City _____ State _____ Zip Code _____

Referral

Referred by: _____ Previous MD _____
Patients heard about Dr. Lipschultz from: Another patient of Dr. Lipschultz Friend Phonebook
 Newspaper Radio or TV Magazine or book Another homeopath Other

Current Medical Illnesses

Please list your current medical problems, including those conditions which have brought you to Homeopathic Treatment.

Current Medical Problems _____ Pl _____

Registration Information - Adult

Name _____ Date _____

Immunizations

Please indicate the kind of immunization and age (or ages) or year at which it was given

D-P-T _____	Measles-Mumps-Rubella (MMR) _____	
Polio _____	Smallpox _____	
Tetanus _____	Hepatitis _____	

Health Questionnaire

Please indicate if you have been bothered by any of the following problems during the last year.

- _____ Feel warmer or cooler than others
- _____ Loss of gain of weight (>15)
- _____ Difficulty getting to sleep
- _____ Wake during the night
- _____ Fever or chills
- _____ Motion sickness
- _____ Night sweats
- _____ Excessive sweating
- _____ Hot flashes

- _____ Frequent or severe headaches
- _____ Neck pains
- _____ Neck lumps, swollen glands
- _____ Loss of balance
- _____ Dizzy spells
- _____ Fainting
- _____ Wear glasses
- _____ Worsening eyesight
- _____ Flashing lights, double vision
- _____ Eye pains

- _____ Hearing problems
- _____ Earaches
- _____ Noises in the ears

- _____ Dental problems
- _____ Bleeding gums
- _____ Receding gums

- _____ Congested nose
- _____ Running nose
- _____ Sneezing spells
- _____ Frequent head colds
- _____ Hayfever
- _____ Nose bleeds
- _____ Sinus infections
- _____ Frequent sore throats
- _____ Difficulty swallowing
- _____ Hoarse voice

- _____ Wheezing
- _____ Frequent coughing
- _____ Cough up phlegm
- _____ Cough up blood
- _____ Frequent bronchitis
- _____ Asthma

- _____ Skipped heart beats
- _____ Palpitations
- _____ Chest pains
- _____ Shortness of breath
- _____ Swollen ankles
- _____ Water retention

- _____ Recurring indigestion
- _____ Frequent belching
- _____ Nausea
- _____ Vomiting
- _____ Loss of appetite
- _____ Always hungry
- _____ Food allergies or sensitivities
- _____ Pain in abdomen
- _____ Pain in stomach
- _____ Heartburn
- _____ Constipation
- _____ Loose stools, diarrhea
- _____ Black stools
- _____ White stools
- _____ Blood in the stool
- _____ Pain in the Rectum
- _____ Hemorrhoids

- _____ Frequent Urination
- _____ Involuntary escape of urine
- _____ Burning with urination
- _____ Brown, black, or bloody urine
- _____ Weak urine system
- _____ Difficulty starting urination
- _____ Constant urge to urinate
- _____ Frequent urinary infections
- _____ Get up at night to urinate

- MEN ONLY:**
- _____ Burning or discharge
 - _____ Lumps or swelling on testicles
 - _____ Painful testes
 - _____ Hernia
 - _____ Rashes, eruptions, or warts
 - _____ Enlarged prostate

- _____ Aching in muscles or joints
- _____ Swollen joints
- _____ Back pains
- _____ Injury to neck or back
- _____ Weakness in legs or arms
- _____ Painful feet
- _____ Trembling
- _____ Numbness
- _____ Leg or foot cramps

- _____ Skin problems
- _____ Excema
- _____ Acne
- _____ Psoriasis
- _____ Itching or burning skin
- _____ Hives

- _____ Nervousness or anxiety
- _____ Nervous with strangers
- _____ Nail biting
- _____ Difficulty making decisions
- _____ Lack of concentration
- _____ Absentminded or loss of memory
- _____ Depression
- _____ Frequent crying
- _____ Hopeless outlook on life
- _____ Difficulty relaxing
- _____ Worry a lot
- _____ Feelings of depression
- _____ Shy or sensitive
- _____ Dislike criticism
- _____ Angered easily
- _____ Annoyed by small things
- _____ Family problems
- _____ Problems at work
- _____ Change of interest in sex
- _____ Thoughts about suicide
- _____ Under excessive stress
- _____ Currently seeing a therapist
- _____ Unusual fatigue

- WOMEN ONLY:**
- _____ A missed period
 - _____ Menstrual problems
 - _____ Bleeding between periods
 - _____ Pain before or with periods
 - _____ Mood changes before or with periods
 - _____ Breast pain before or with periods
 - _____ Heavy bleeding
 - _____ Bearing down feeling
 - _____ Vaginal discharge
 - _____ Eruptions, rashes, or warts
 - _____ Pain with intercourse
 - _____ Lumps, swelling, or pain in breasts
 - _____ Vaginal or "yeast" infections
 - _____ Number of pregnancies
 - _____ Number of births
 - _____ Number of miscarriages
 - _____ Premature births
 - _____ Cesarean births
 - _____ Number of Abortions

Comments or special problems:

Registration Information - Adult

Name _____ Date _____

Medications

Allergies to Medications _____

If you use or have used any of the following, please list the name and the dosage.

	Current	Past
Birth Control Pills	_____	_____
Thyroid	_____	_____
Hormones	_____	_____
Topical Ointments	_____	_____
Heart Medications	_____	_____
Antihistamines	_____	_____
Vitamins	_____	_____
Non-Prescription	_____	_____
Tranquilizers	_____	_____
Other Medications	_____	_____

If you use any of the following, please list the amount.

Coffee or Tea _____ Cigarettes _____ Alcohol _____

Have you ever been treated with any form of Cortisone (steroids), either pills, sprays, ointments, or injections?
 Cortisone (name, dose, and date) _____

Past History

Cancer (type, treatment, and date) _____

Skin problems (excema, psoriasis, hives, or ringworm); type and years _____

Surgery (type and year) _____

Past Medical Problems (illness and year) _____

Family

(Indicate brothers (Br) or sisters (Sis) by circling the correct initials)

	Age	Deceased (Age)	Living with you	Allergies	Arthritis	Asthma	Cancer	Diabetes	Heart and High BP	Mental Illness	Skin Disorders	Tuberculosis	Weight Problems
Father													
Mother													
Br or Sis													
Br or Sis													
Br or Sis													
Br or Sis													
Child													
Child													
Child													

	Age	Deceased (Age)	Living with you	Cancer	Diabetes	Heart and High BP	Mental Illness	Tuberculosis
Father's Mother								
Father's Father								
Mother's Mother								
Mother's Father								
Other _____								
Other _____								
Other _____								

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HOMEOPATHIC TREATMENT AUTHORIZATION- ADULTS

I, _____ am over 18 years of age today, _____ and have chosen Homeopathy as the preferred method of health care. The book, Everyday Miracles by Dr. Linda Johnston, can be purchased at our office or can be ordered through a local bookstore. Local libraries may carry it as well.

I acknowledge that prior to any Homeopathic Remedy I have had all of my questions about Homeopathy resolved by Carol H. Lipschultz, D.C.

As a result, I believe that I have sufficient information, and have decided to use Homeopathy for my health care. I am aware that this system is an alternative to conventional methods.

I understand that Homeopathy views health and illness in a holistic manner. This view is different from the standard, conventional approach which usually limits its concerns to isolated physical, emotional and mental aspects of the human being as important. The homeopath will rely on symptoms from all these areas. Improvement in my health will be evaluated from a total view in all these areas. I understand that there may be occasions when an aggravation of the current or a return of previous symptoms may occur as part of the healing process.

ANTIDOTE

I have received and reviewed a list of substances that will interfere with the action of the Homeopathic remedy known as the Antidote List. I agree to refrain from using anything on the list. Should the occasion arise that I need any of these items, I will call Carol H. Lipschultz, D.C., to discuss the situation. Use of any of these items on the Antidote List could result in termination of Homeopathic care.

HOMEOPATHIC REMEDY

To provide the greatest possible benefit to me during Homeopathy, I leave the decision of informing me of the name of my Homeopathic Remedy to Carol H. Lipschultz, D.C.. Typically, this is done after the action of the remedy is evident and has been confirmed.

CONSULTATION

I authorize Carol H. Lipschultz, D.C., to video tape appointments, release and discuss my case with other professional Homeopaths should assistance in remedy selection, symptom analysis be required for my best interests.

HOMEOPATHIC TREATMENT AUTHORIZATION- ADULTS

Name _____ Date _____

COSTS

Fees for Homeopathic consultation for adults (ages 16 & up) are:

Initial Evaluation	\$250.00
Follow-up Evaluation	\$ 67.00
Liquid Remedy	\$ 3.00

CHANGES IN APPOINTMENTS

A forty-eight (48) hour notice is required if appointment times need to be changed. I understand that I will be responsible for the fees of cancelled appointments without forty-eight (48) hours notice.

INSURANCE

I understand that payment for all services is due in full at the time of the service. I am financially responsible for all charges. At this time insurance does not pay for homeopathy services and/or supplies.

ARBITRATION

Arbitration is a private, informal process by which two people agree, in writing, to submit a dispute to an impartial party authorized to resolve the problem. This process will render a final and binding decision.

I understand that in the event that any dispute arising out of services provided to me, or the cost thereof, or for any reason shall be settled by arbitration in accordance with the rules of the American Arbitration Association. Judgment upon the award rendered by the arbitrator(s) may be entered in any court have jurisdiction.

Patient _____

Date _____

Witness _____

Date _____

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EVENTS

BEFORE your next homeopathy appointment please make a chronological list of any significant events in your life. Include all major physical and or emotional-mental events. Try to remember the year and date of these events.

This is just a place to start for the interview. Please do the best you can and **include the following:**

- Any event that you see as significant
- Births of siblings
- Moves
- Marriages (yours)
- Divorces (yours or your parent's)
- Any major illness you experienced
- Any car accidents
- Major accidents of any kind
- Hospitalizations
- Surgery
- Deaths of relatives/friends that had a profound effect
- Any events that caused a change in your life

Here are some examples:

- Dec. 20, 1950 - Birth
- Jan. 15, 1951 - Pneumonia
- June 12, 1951 - Father went to Korea for one year
- March 20, 1954 - Sister Mary was born
- Sept. 14, 1955 - Moved out of state
- Dec. 11, 1955 - Sick with a cough for 3 months
- Sept. 6, 1956 - Started first grade
- Dec. 20, 1956 - Throat infection
- March, 1967 - Had mono for two months
- April, 1980 - Mother died
- June, 1985 - Divorced
- August, 1985 - Rash on arm started
- February, 1988 - Married
- March, 1988 - Back injury
- May, 1988 - Surgery on back
- March 3, 1974 - First Child was born
- May, 1978 - Quit drinking
- Jan. 31, 1969 - Car accident, broken hip, internal bleeding

ALLERGY QUESTIONNAIRE

NAME _____ DATE _____

DATE OF BIRTH _____

Please fill in the blanks and circle applicable answers. Feel free to add additional comments. Base your answers on your own observations, NOT on what you have been told by friends or other physicians.

SYMPTOMS

SNEEZING	YES NO	SHORTNESS OF BREATH	YES NO
RUNNY NOSE	YES NO	WHEEZING	YES NO
NASAL CONGESTION	YES NO	COUGH	YES NO
EAR CONGESTION	YES NO	SINUSITIS	YES NO
ITCHY EYES	YES NO	HIVES	YES NO
PUFFY EYES	YES NO	ECZEMA	YES NO
HEADACHES	YES NO	DIZZINESS	YES NO
BRONCHITIS	YES NO	OTITIS	YES NO

ARE YOU WORSE IN ANY SEASON?

SPRING
SUMMER
FALL
WINTER

HAVE YOU EVER HAD

AN ALLERGIC REACTION TO AN ANTIBIOTIC?
TO WHAT? YES NO

AN ALLERGIC REACTION TO ANY OTHER DRUG?
TO WHAT? YES NO

AN ALLERGIC REACTION TO A BEE STING?
WHICH KIND OF BEE? YES NO

A SEVERE ALLERGIC REACTION TO ANYTHING?
TO WHAT? YES NO

AN ANAPHYLACTIC REACTION TO ANYTHING?
TO WHAT? YES NO

A PREVIOUS ALLERGY WORKUP?
BY WHOM? YES NO
WHEN?

OCCUPATION: _____

DO YOU WORK AROUND:
DUST AND DIRT? YES NO
CHEMICALS? YES NO
ANIMALS? YES NO

DO YOU HAVE ANY PROBLEMS AT WORK? YES NO

IF YES, PLEASE DESCRIBE BELOW :

HOUSING

TYPE OF HOUSING

- APARTMENT
- SINGLE FAMILY TWO STORY
- SINGLE FAMILY SPLIT ENTRY
- CONDOMINIUM
- TRAILER

AGE OF HOUSING

- NEW
- 5- 10 YRS
- 11-20 YRS
- 21-50 YRS
- OVER 50 YRS

HEATING SYSTEM

- GAS, FORCED-AIR
- GRAVITY
- RADIATORS- HOT WATER
- ELECTRIC
- WOOD
- SPACE HEATERS

BASEMENT

- NONE (SLAB)
- CRAWL SPACE ONLY
- CONCRETE FLOOR
- DIRT FLOOR
- STONE WALLS
- CONCRETE BLOCK WALLS
- FINISHED
- CARPETED

BEDDING & LINEN

- DOWN COMFORTERS
- WOOL BLANKETS
- COTTON BLANKETS

- WINDOW TREATMENTS
- DRAPES-DRY CLEAN
- WASHABLE DRAPES OR CURTAINS
- BLINDS- FABRIC
- BLINDS- METAL OR WOOD

HOUSEHOLD PRODUCTS USED

- LYSOL/ PINESOL
- AIR FRESHENERS
- PERFUMES/ AFTERSHAVE LOTIONS
- SHEET-TYPE DRYER SOFTENERS

KITCHEN

- GAS STOVE
- ELECTRIC RANGE
- SELF-DEFROSTING REFRIGERATOR

BEDROOM

- MATTRESS:- list ages
- INNERSPRING
 - FOAM RUBBER

PILLOWS:

- POLYESTER
- FEATHER
- DOWN
- FOAM

LIST THE NUMBERS AND TYPES BELOW :

- | | |
|--|---|
| <input type="checkbox"/> NUMBER OF ADULTS LIVING TOGETHER | <input type="checkbox"/> NUMBER OF CATS |
| <input type="checkbox"/> NUMBER OF CHILDREN | <input type="checkbox"/> NUMBER OF DOGS |
| <input type="checkbox"/> NUMBER OF SMOKERS (FREQUENT) | <input type="checkbox"/> NUMBER OF BIRDS |
| <input type="checkbox"/> NUMBER OF SMOKERS (OCCASIONAL) | <input type="checkbox"/> NUMBER OF OTHER PETS -
INSIDE |
| <input type="checkbox"/> NUMBER OF HORSES OUTSIDE | |
| <input type="checkbox"/> NUMBER OF OTHER ANIMALS OUTSIDE | |
| <input type="checkbox"/> LIST MOST RECENT YEAR FURNACE DUCTS WERE PROFESSIONALLY CLEANED | |
| <input type="checkbox"/> IS BASEMENT DRY OR DAMP? | |
| <input type="checkbox"/> HAVE THERE BEEN ANY MAJOR PROBLEMS IN YOUR HOUSING-(FLOODING, FIRE,
ETC) | |

FOODS

Please state how often you eat these:

	DAILY	1-2/ WK	1-2/ MO	1/ MO	RARELY	NEVER
FRUITS						
APPLES						
BANANAS						
GRAPES						
ORANGES						
PEACHES						
PEARS						
PINEAPPLE						
STRAWBERRIES						
RASPBERRIES						
GRAINS						
BARLEY						
MILLET						
OATS						
RICE						
RYE						
WHEAT						
OILS						
ALMOND						
CANOLA						
CORN						
COTTONSEED						
PEANUT						
SAFFLOWER						
SESAME						
SOY						
SUNFLOWER						
WALNUT						
VEGETABLES						
ASPARAGUS						
CABBAGE						
CARROTS						
CELERY						
CORN						
CUCUMBER						
GREEN BEANS						
GREEN PEAS						
KIDNEY BEANS						
LETTUCE						
ONION						
POTATO						
SPINACH						
SQUASH						
TOMATOE						

FLOORING--list age where appropriate:

	CARPET	WOOD	VINYL	TILE	CONCRETE
LIVING ROOM					
DINING ROOM					
KITCHEN					
MASTER BEDROOM					
2ND BEDROOM					
3RD BEDROOM					
FAMILY ROOM					
BASEMENT					
BATHROOM #1					
BATHROOM #2					

ARE YOU WORSE IN ANY OF THE FOLLOWING LOCATIONS/CONDITIONS ?

- | | | |
|-----|----|--------------------------------------|
| YES | NO | OUTDOORS |
| YES | NO | INDOORS |
| YES | NO | IN AIR CONDITIONING |
| YES | NO | AFTER THE FURNACE HAS BEEN TURNED ON |
| YES | NO | IN A BASEMENT |
| YES | NO | WITH CEILING FANS RUNNING |
| YES | NO | IN CERTAIN ROOMS |
| YES | NO | WHILE DUSTING OR SWEEPING |
| YES | NO | IN DAMP PLACES |
| YES | NO | WHILE MOWING GRASS |
| YES | NO | WHEN EXPOSED TO HAY |
| YES | NO | WHILE NEAR A BARN |
| YES | NO | WHILE NEAR A CIRCUS |
| YES | NO | AFTER AUGUST 15 |
| YES | NO | WHILE RAKING LEAVES |
| YES | NO | AROUND COMPOST |
| YES | NO | IN THE COOL EVENING AIR |
| YES | NO | IN THE LATE EVENING |
| YES | NO | BETWEEN 1 AND 5 AM |
| YES | NO | WHEN EATING CHEESE |
| YES | NO | WHILE EATING MUSHROOMS |
| YES | NO | WHILE DRINKING BEER |
| YES | NO | WHILE DRINKING WINE |

Please state how often you eat these:

	DAILY	1-2/ WK	1-2/ MO	1/ MO	RARELY	NEVER
MEATS						
BEEF						
CHICKEN						
CODFISH						
PORK						
SALMON						
SHRIMP						
TURKEY						
MISCELLANEOUS						
ALMONDS						
BEET SUGAR						
CANE SUGAR						
CASHEWS						
CHEESE						
CHOCOLATE,ATE						
CINNAMON						
COCONUT						
COFFEE						
EGG						
GARLIC						
GINGER						
MALT						
MILK						
MUSHROOM						
MUSTARD						
NUTS- OTHER						
PEANUT						
PECANS						
POP						
POPCORN						
SOY SAUCE						
TEA						
VITAMIN PILLS						
WALNUTS						

LIST FOODS THAT HAVE EVER CAUSED ANY OF THE FOLLOWING REACTIONS:

ALLERGIC/ANAPHYLACTIC:

THEY DISAGREE WITH YOU:

YOU AVOID THEM FOR ??? REASON:

YOU CRAVE THEM:(what foods)

CHEMICALS -----Place one check mark next to any chemical that bothers you and two check marks next to any chemical that makes you really sick.

- _____ ODOR OF ESCAPING OR BURNING UTILITY GAS
- _____ ODOR OF GASOLINE, GARAGE FUMES AND ODORS
- _____ AUTOMOBILE OR BOAT EXHAUSTS
- _____ ODOR OF NAPHTHA, CLEANING FLUIDS, OR LIGHTER FLUIDS
- _____ ODOR OF RECENTLY CLEANED CLOTHING, UPHOLSTERY OR RUGS
- _____ ODOR OF NAIL POLISH OR POLISH REMOVER
- _____ ODOR OF FRESH NEWSPAPER
- _____ ODOR OF KEROSENE
- _____ ODOR OF FUEL OIL, BURNING SPACE HEATERS, OR FURNACES
- _____ DIESEL ENGINE FUMES FROM TRAINS, BUSES, TRUCKS, OR BOATS
- _____ LUBRICATING GREASES OR CRUDE OIL
- _____ FUMES FROM AUTOMOBILES BURNING EXCESSIVE AMOUNTS OF OIL
- _____ ODOR OF FLOOR OR FURNITURE WAX
- _____ ODOR OF GLASS WAX OR GLASS CLEANERS
- _____ FUMES FROM BURNING WAX CANDLES
- _____ FUMES FROM TARRING ROCKS AND ROADS
- _____ ASPHALT PAVEMENT IN HOT WEATHER
- _____ TAR-CONTAINING SOAPS, SHAMPOOS, OINTMENTS
- _____ ODOR OF INK, CARBON PAPER, OR TYPEWRITER RIBBON
- _____ DYES IN CLOTHING AND SHOES
- _____ DYES IN COSMETICS-
- _____ ODOR OF PUBLIC OR HOUSEHOLD DISINFECTANTS OR DEODORANTS
- _____ ODOR OF LYSOL
- _____ FUMES FROM BURNING CREOSOTE TREATED WOOD (RAILROAD TIES)
- _____ HOUSEHOLD DETERGENTS
- _____ ODOR OF SPONGE RUBBER BEDDING, RUG PADS, TYPEWRITER PADS
- _____ NYLON HOSIERY OR OTHER NYLON CLOTHING
- _____ DACRON OR ORLON CLOTHING OR UPHOLSTERY
- _____ RAYON OR CELLULOSE ACETATE CLOTHING OR UPHOLSTERY
- _____ ODOR OF RUBBING ALCOHOL
- _____ ODOR OF VARNISH, LACQUER, OR SHELLAC
- _____ ODOR OF AFTER-SHAVE LOTION, HAIR SPRAYS, OR HAIR DRESSINGS
- _____ ODOR OF PAINT OR VARNISH THINNED WITH MINERAL SOLVENTS
- _____ ODOR OF SCENTED SOAP AND SHAMPOO
- _____ ODOR OF PERFUME AND COLOGNES
- _____ ODOR OF CHRISTMAS TREES AND EVERGREEN DECORATION
- _____ ODOR OF SHEET-TYPE FABRIC SOFTENERS (FOR DRYER)