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|  | Allergy AnalysisFu’s Natural Healing CentreUnit 15, Small Heath Business Centre, 411 – 421, Coventry Road, Birmingham, B10 0TH, | Tel: 0121 2938 587 0788630505207950897308 |
| The information you give assists us in establishing any allergic reactionrelated to your symptoms. Please be concise and take time to answer all questions.  Please **PRINT**  information **CLEARLY** in **CAPITAL LETTERS**. |
| **Date:** |  **Digestion:**  ❑ **IBS** ( Irritable Bowel ) ❑ Wind ❑ Diarrhoea ❑ Heartburn❑ Constipation ❑ Indigestion❑ **other :** |
| **Title:** ❑**Mrs** ❑Miss ❑MS ❑**Mr** ❑Master  |
| **First name:** |
| **Surname:** |
| **Gender:** ❑ **Male** ❑ **Female** | **Skin:** ❑ Acne ❑ Spots/Pimples ❑ Dermatitis /Eczema ❑ Psoriases❑ Rashes / Itching Skin❑ Urticaria (Hives) | ❑ Scalp ❑ Face ❑ Neck ❑ Arms ❑ Elbow❑ Hands ❑ **other:** | ❑ Chest❑ Back ❑ Legs ❑ Knees❑ Feet  |
| **Date of birth : Age:** |
| **Address:**………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………Post Code: ……………………………………..……….. **Tel:** …………………………………………………………………………………. ……………………………………………………………………………………. |
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| **Aches and pains:**❑ Rheumatoid Arthritis ❑ Osteoarthritis |
| **Please indicate:** | ❑ Hands❑ Wrists ❑ Arms❑ Elbows❑ Shoulders ❑ Neck  ❑ **other***:*  | ❑ Back ❑ Hips ❑ Knees ❑ Feet❑ Ankles❑ Toes  |
|  **Do you have any known Allergies?**   ❑ no❑ yes: ………………………………………………………………...……….………………………………………………………………….. **PLEASE LIST ALL KNOWN ALLERGIES!****Are you:** ❑ Vegan ❑Vegetarian ❑ Smoker ❑ Pet Owner Have you had in the past 3 years:  ❑ Vaccination ❑ X-Ray ❑ Antibiotics  **Are you currently taking any** **medication?**  Please list ❑ no ❑ yes:…………….…………………………………………………….… ……………………………………….………………………………**Are you taking any** **Vitamins, Minerals** **or other Supplements**? Please list  ❑no ❑yes**:**…………………………………………………………….……………………..……………………………………………..……………...………….……… |
| **Other conditions present:** |
| ❑ Migraines ❑ Headaches❑ Hyperactivity❑ Irritability❑ Painful Periods❑ Water Retention ❑ Cystitis |  ❑ Asthma ❑ Breathing Problems❑ Rhinitis ❑ Catarrh❑ Coughing❑ Hay Fever❑ Itchy eyes |
|   |
| **Babies & small children (2-3):****Mothers,** please indicate if you are **Breastfeeding**: ❑ yes ❑ full ❑ partially  ❑ noplease listfoods/formulas**:** ………………….……………………………………………………………………..…..……………………………………………………………………………………………..………………………………………………………………….…………………………. |  ❑  **Other health problems:** Please list:Form filled in by client ❑no ❑yesClients Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:  |

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