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| --- | --- | --- | --- | --- | --- |
|  | Allergy Analysis Fu’s Natural Healing Centre  Unit 15, Small Heath Business Centre,  411 – 421, Coventry Road, Birmingham, B10 0TH, | | | Tel:  0121 2938 587  07886305052  07950897308 | |
| The information you give assists us in establishing any allergic reaction  related 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 ❑yes  Clients Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: | | | |

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