Epter Chiropractic●100 West Indiantown Road ● Jupiter Florida 33458 ● 561 575-4400

Patient Name: **_____** ***Date:*** **_____**
Address: _____ **Date of Birth: _____**
City, State, Zip: _____ **Phone #: _____**
Gender: MALE ___ FEMALE ___ **Email: _____**
Primary Care Physician: _____ **Referring Physician: _____**

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand.

- *We do not treat symptoms or disease.*
- *An allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlining cause.*
- *We do not use drugs in this program.*
- *There is no single "healthy" diet that will work for everyone.*
- *Just because food is considered "healthy", does not mean it is "healthy" for you.*
- *Your diet consists of everything you* ***eat, drink, rub on your skin, or inhale****.*
- *Our procedures are safe and painless.*

Briefly describe the reason for your visit and what you hope to accomplish:

_____

AGE WHEN SYMPTOMS WERE FIRST OBSERVED

☐ Infant (Age 0-2) ☐ Child Age (Age 3-5) ☐ Child (Age 6-12)
☐ Adolescent (Age13-18) ☐ Adult (age 19-25 ☐ Adult (Age 26-40)
☐ Adult (Age 41 and over)

PREVIOUS ALLERGY EVALUATION

Have you ever seen an allergist? ☐ Yes ☐ No
Have you had allergy skin testing? ☐ Yes ☐ No
Did you have any positive reaction? ☐ Yes ☐ No
If yes, please list positive allergens (including any medications) _____
Have you ever received allergy injections? _____

WORK ENVIRONMENT

What is your occupation? _____ Are you exposed to chemicals or strong odors at work? _____
If yes, briefly explain _____ Are your symptoms worse while at work? _____
If yes, briefly explain _____
ANY ADDITIONAL INFORMATION YOU WOLD LIKE US TO KNOW? _____
_____

WHEN ARE YOUR SYMPTOMS WORSE Year round

□ January	□ February	□ March	□ April	□ May	□June
□ July	□ August	□ September	□ October	□ November	□December

MEDICATIONS

Doyou take any of the following medications on a regular basis?
Antibiotics: _____
Antihistamines (Benadryl, Actifed, Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp, Drixoral, Trimalin, Atarax Claritin, Allegra, Zyrtec, etc.)

Bronchodilators (Albuterol, Ventolin, Proventil, Serevent, or OTS's such as Primatine Mist, etc.}

Steroid inhalers (Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair etc.}

Nasal Steroids (Beconase, Flonase, Nasacort, Rhinocort, etc.)

Medication that affect the immune system (Prednisone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus, etc.)

Chemotherapy
Please list any medications that you are currently taking: _____

SMOKING

Do you smoke? ___ Number of cigarettes per day ____ A what age did you start? ___ Anyone smoke in your house? ___

FOOD RELATED SYMPTOMS

□Symptoms flare 5-60 minutes after meals	□Some foods are craved or addictive
□The smell or odor of some foods increases symptoms	□Some foods cause nasal symptoms
□Some foods cause swelling of the mouth or tongue	□Some foods cause rashes or hives
□Some foods causes upset stomach or vomiting	□Some foods cause diarrhea
□ Symptoms occur with restaurant salad bars or Asian foods	□ Some foods causes headaches
□ Symptoms occur with any regularly eaten food	□ Some foods cause asthma
□ Preservatives, additives or food coloring increases symptoms	□ No problem with foods

FOODS THAT CAUSES SYMPTOM FROM ONE HOUR TO THREE DAYS AFTER EXPOSURE

□Eggs	□Milk	□Beef	□Corn	□Wheat	□Soybean
□Peanut	□Pork	□Fish	□Shellfist	□Orange/citrus	□Potato
□Tomato	□Yeast	□Chocolate	□Coffee/Tea	□None	□Other

CHEMICALS THAT CAUSE SYMPTOMS

□Insecticides & pesticides	□Paints &household cleaners	□Perfumes & cosmetics
□Gasoline & auto exhaust	□Stove or furnace emissions	□The smell of new fabrics or fabric store
□Chemicals in the work place	□Laundry detergent	□Newsprint

Other _____ None _____

DID YOU SUFFER FROM ANY TYPE OF PHYSICAL, CHEMICAL OR EMOTIONAL TRAUMA JUST BEFORE YOUR SYMPTOMS WERE FIRST OBSERVED? _____

HAVE YOUR SYMPTOMS EVER GONE AWAY FOR ANY PERIOD OF TIME? _____

PREVIOUS DIAGNOSIS OF ALLERGY?

☐ Yes and allergy shots helped ☐ Did not help ☐ Yes medication helped ☐ Did not help ☐ None

FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

☐ Mother ☐ Father ☐ Brother/Sister ☐ Grandparents
☐ Son/Daughter ☐ Spouse ☐ None

FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS

☐ Constant/Chronic with little change
☐ Present part of the time
☐ Prevents some normal activities
☐ Slight interference with normal life
☐ Present most of the time
☐ Present rarely
☐ Considerable interference with normal life
☐ No interference with normal life

SYMPYOMS ARE WORSE

☐ Outdoors and better indorse
☐ In the bedroom or when in bed
☐ During wet or damp weather
☐ During known pollen seasons
☐ When exposed to tobacco smoke
☐ When sweeping or dusting the house
☐ In air conditioning
☐ Tobacco smoke bothers me more than anything else
☐ At nighttime
☐ During windy weather
☐ When the weather changes
☐ In certain rooms or buildings
☐ With yard work, cut grass, leaves, hay or barns
☐ In areas with mold or mildew
☐ In fields or in the country

SYMPTOMS ARE BETTER

☐ After shower or bath ☐ In air conditioning ☐ Indoors
☐ During or after physical activity ☐ After taking antihistamines ☐ With allergy shots
What makes you feel better? _____

ANIMAL, INSECTS AND BIRDS THAT CAUSE SYMTOMS ON EXPOSURE

☐ Dogs ☐ Cats ☐ Horses or Cattle
☐ Rabbits ☐ Birds or Feathers ☐ Rodents (mice, guinea pigs, etc.)
☐ Bees ☐ None ☐ Other _____

Have You Been Vaccinated Against Communicable Diseases - Yes____ No___

Have You experienced and adverse reactions or symptoms after vaccination administered Yes____ No ____

At What Age were symptoms / reactions experienced _____

Name of Vaccine _____ (age in months,years) _____

Name of Vaccine _____ (age in months,years) _____

Name of Vaccine _____ (age in months,years) _____

PLEASE CHECK OFF THE FOLLOWING THAT APPLY TO YOU

Digestive Track
- ☐ nausea & vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ bloated feeling
- ☐ stomach pains or cramps
- ☐ heart burn
- ☐ blood and/or mucous in stools

TOTAL ____

Ears
- ☐ itchy ears
- ☐ ear aches/ear infections
- ☐ drainage from ear
- ☐ ringing in ears
- ☐ hearing loss
- ☐ reddening of ears

TOTAL ____

Emotions
- ☐ mood swings
- ☐ anxiety/fear/nervousness
- ☐ anger/irritability/aggressiveness
- ☐ argumentative
- ☐ frustrated/cries easily
- ☐ depression

TOTAL ____

Eyes
- ☐ watery or itchy eyes
- ☐ red/swollen/itchy eyelids
- ☐ bags or dark circles under eyes
- ☐ blurred or tunnel vision

TOTAL ____

Head
- ☐ headaches
- ☐ faintness
- ☐ dizziness
- ☐ insomnia/sleep disorder
- ☐ facial flushing

TOTAL ____

Heart
- ☐ irregular/skipped heartbeat
- ☐ rapid/pounding heartbeat
- ☐ chest pain

TOTAL ____

Joints & muscles
- ☐ pains/aches in joints
- ☐ arthritis/osteoarthritis
- ☐ stiffness/limited movement
- ☐ pain/aches in muscles
- ☐ feeling weak/tired
- ☐ swollen/tender joints
- ☐ growing pains in legs
- ☐ psoriatic/gouty arthritis

TOTAL ____

Lungs
- ☐ chest congestion
- ☐ asthma/bronchitis
- ☐ shortness of breath
- ☐ difficult breathing
- ☐ persistent cough
- ☐ wheezing

TOTAL ____

Mind
- ☐ poor memory
- ☐ difficulty completing projects
- ☐ difficulty with mathematics
- ☐ underachiever
- ☐ poor/short attention
- ☐ confusion
- ☐ easily distracted
- ☐ difficulty making decisions
- ☐ learning disabilities

TOTAL ____

Mouth & Throat Thrush
- ☐ chronic coughing
- ☐ gagging/clearing throat often
- ☐ sore throat/hoarse voice/voice loss
- ☐ swollen/discolored tongue/lips
- ☐ cancer sores
- ☐ itching on roof of mouth

TOTAL ____

Nose
- ☐ stuffy nose
- ☐ chronically red/inflamed nose
- ☐ sinus problems
- ☐ hay fever
- ☐ sneezing attacks
- ☐ excessive mucous formation

TOTAL ____

Skin
- ☐ acne
- ☐ itching
- ☐ hives/rash/dry skin
- ☐hair loss
- ☐ flushing/hot flashes

TOTAL ____

Weight
- ☐ binge eating/drinking
- ☐ craving certain foods
- ☐ excessive weight
- ☐ compulsive eating
- ☐ water retention

TOTAL ____

Genitourinary
- ☐ kidney
- ☐ frequent/urgent urination
- ☐ bladder
- ☐ yeast infections
- ☐ genital itch/discharge/anal itching
- ☐ yeast infections

TOTAL ____

Other conditions
- ☐ Autism
- ☐ A.D.H.D.
- ☐ A.D.D.
- ☐ Psoriasis
- ☐ Eczema
- ☐ Auto Immune Disorder
- ☐ Chronic Fatigue
- ☐ Multiple Chemical Sensitivities
- ☐ Asthma
- ☐ Congestive Heart Failure
- ☐ Sever Diabetes
- ☐Severe Depression
- ☐ Obsessive Compulsive Disorder

Symptoms of Hypothyroidism(Overcoming THYROID Disorders, David Brownstein, MD)

- Fatigue, sluggishness or weakness
- Dry skin
- Brittle nails
- Hair loss and/or coarse or dry hair
- Increased sensitivity to cold
- Constipation
- Memory problems or having trouble thinking clearly
- Heavy or irregular menstrual periods
- Weight gain
- Swelling of the arms, hands, legs, and fee
- Facial puffiness, especially around the eyes
- Hoarseness
- Muscle aches and cramps
- Low blood pressure
- Elevated blood cholesterol
- Infertility
- Sleep irregularities
- Depression

Thytrophin PMG for Hypothyroidism

Symptoms of Iodine Deficiency (Iodine why you need it, David Brownstein, MD)

- ADD/ADHD
- Atherosclerosis
- Breast Disease
- Dupuytren's Contracture
- Excessive Mucous Production
- Fatigue
- Fibrocystic Breasts
- Goiter
- Hemorrhoids
- Headaches and Migraine Headaches
- Hypertension
- Infections
- Keloids
- Liver Disease
- Nephrotic Syndrome
- Ovarian Disease
- Parotid Duct syndrome
- Peyronie's
- Prostate Disorders
- Sebaceous Cysts
- Thyroid Disorders
- Vaginal Infections

IODINE PATCH TEST INSTRUCTIONS

1. Begin the test in the morning (after showering)
2. Use Tincture of Iodine to paint asize of quarter (25 cents) on the inner arm
   Tincture of Iodine is available from any drug store or pharmacy. Be sure it's the
   Original orange colored solution not the clear solution. Make the following notes.
   - Hour patch begun to lightened :_____ : _____ am/pm
   - Hour patch disappeared completely:_____ : _____ am/pm
3. Write down your starting time:_____ : _____ am/pm
4. Observe the coloration of the patch over the next 24 hours.
5. Describe the site after 24 hours: _____
6. Any other observations or comments:_____

- Patch begins to slightly lighten after 24—NORMAL
- Patch almost disappears in under 24 hours consider **Iodomere**(standard process)2-3 or more per day
- Patch disappears, oralmost in under 10 hours consider **Prolamine Iodine**(standard process)1-2 or more per day

Repeat patch test ever 2 weeks, when patch no longer disappear after 24 hours lower iodine dose appropriately

The day of your appointment:

Our testing is performed on a strict schedule, so please be on time. The following reminders will make your visit go more smoothly.

- Do not take any supplements or unnecessary medications for an hour before your appointment.
- Avoid eating one hour before your appointment.
- Please drink a lot of water for 24 hours before your appointment.
- Most treatments involve acupuncture points on the lower leg, forearms and back. Gowns are provided, but you may want to wear loose pants that can roll up and a white sheer shirt in place of wearing a gown.
- Please do not wear perfume, strong smelling deodorant, fragrances, essential oils, hand lotion, aftershave or cologne on the day of your visit.
- If you need to reschedule your appointment, please do so the day before your appointment.

After your treatment:

For three hours after your treatment we recommend, if possible, do not:

- Visit Hair Salon, Barber Shop, or Nail Salon
- Go shopping
- Put gasoline in your car
- Chew gum, use breath mints
- Drink anything except water
- Eat anything
- Do anything that is highly stressful or stimulating
- Do not have a massage, Acupuncture, Vigorous Exercise, Hot Tub, Sauna, Steam Room or swimming

  (This is to avoid exposure to foods and chemicals that you eat, drink, breath or put on your skin, and is recommended for best results.

  You may be able to break some or all of these rules and do just fine, but to have the best results follow all these suggestions. The restrictions are for three hours, a small price to pay for long term benefit.)

EPTER CHIROPRACTIC
Jack L. Epter D.C
100 West Indiantown Road
Jupiter Florida 33458

INFORMED CONSENT FORM

Patient Name_____ **Telephone Number**_____

Address_____ **City & State**_____

Email:_____

Background: I desire to be tested to determine possible undesirable reactions to various stressors that are natural constituents of my diet, environment or body chemistry. I understand that the device being used is FDA cleared for Galvanic Skin Response Testing and not intended to directly treat or cure any specific condition, symptom or illness. The physician has explained, and I understand, the benefits of receiving stress reduction and relaxation therapy and the direct relationship between stress, illness and disease.

Procedures: I understand that this is a non-invasive procedure (the skin is not pierced). Homeopathic remedies, nutritional supplements and other natural remedies may be used to bring abnormal electrical patterns into equilibrium. I understand the nature of the immune system and related symptoms are of an unpredictable nature and therefore the facility cannot guarantee any results.

Dr. Jack Epter or Epter Chiropractic cannot guarantee that new stressors will not contribute toward my health conditions in the future and that in some cases a person may not wholly respond to the treatment.

I choose to be and I understand that this testing has not been scientifically proven to be reliable and that my physician must still rely upon my observations as to the efficacy of the test and any treatment based on the results of this test.

Risks: The procedure is very safe because it measures only changes in the electrical properties of the skin. However, since an electrical signal is used there is a slight risk or electrical burn or shock. Skin irritation or redness may occur at the site of the test. However, any discomfort should be brief. There are generally no risks associated with the substances recommended to bring your body to equilibrium as long as those substances are taken as recommended, but please report any discomfort you may experience from taking these substances to your examiner or physician. Please report any significant health problems (i.e. Diabetes, High Blood Pressure, etc.) to your physician. I understand that there is a risk factor where as a result of exposure to these bio-energetic stressors, that I may experience temporary symptoms not unusual to the regular symptoms currently experienced when exposed to these stressors. I assume all responsibility for the unpredictable immune reactions that may lead to increased symptoms. I agree to seek immediate medical attention should this occur and understand that this facility does not treat cases of patients suffering from anaphylactic allergic reactions, neoplasm or cancer, or who have pacemakers, or defibrillators, and during pregnancy,and I agree to completely disclose all information regarding any life threatening allergies or allergies resulting in anaphylaxis, as well as any of the above prior to undergoing these procedures.

Questions: I have been provided with the opportunity to ask any pertinent questions I have regarding the BioScanSRT procedure, protocol or treatment program.

Free to Decline: I understand that I may decline to the testing and therapy.

Important: There is no recognized body of scientific evidence to show that an electrically balanced body is more likely to be healthier and you have chosen to participate in this assessment with that understanding. Your physician may need to use other forms of testing in the course of your treatment.

Payment of Services: You are responsible for the payment of the normal and necessary fees associated with the assessment and services performed as a result of that testing, if purchased in this clinic.

I have read and understand the above information and my rights. I consent to the use of clinical reports and results of my case for study, the purpose of advancing clinical knowledge, research and scientific purposes provided that my identity is kept confidential.

Date_____

Name_____**Signature**_____

Signature of Parent or Guardian if Patient is a minor_____