Allergy/Inflammation Symptom Severity Index

Name: _____ Date: _____

Grade the level of symptom severity that you are currently experiencing according to the following system:

1 = No problem
2 = Rarely (once a month) or minimal
3 = Occasional (once a week) or mild
4 = Frequent (several times a week) or moderate
5 = Daily or severe

Integument-Musculoskeletal
___Dark circles around eyes
___Itching, burning, painful skin
___Flaking skin
___Dry skin
___Skin rash
___Oozing or crust formation
___Hair loss
___Muscle cramps
___Painful, stiff or swollen joints
___Migraines
___Total for section

Cardiovascular-Gastrointestinal
___Heart racing
___Palpitations (skipped beats)
___Upper bowel gas (belching)
___Lower bowel gas (flatulence)
___Reflex (heartburn)
___Bloating, abdominal distention
___Liquid stools
___Greasy stools
___Mucus in stools
___More than 3 stools per day
___Total for section

Eye, Ear, Nose, Respiratory
___Itching, Burning, red or watery eyes
___Runny nose
___Increased mucus production
___Sinus congestion or headache
___Scratchy or sore throat
___Itchy ears, snapping, popping, pain
___Cough
___Frequent colds or ear infections
___Shortness of breath
___Wheezing or coughing in fits
___Total for section

Mental-Emotional
___Difficulty remembering
___Blackouts
___Numbness or tingling
___Want to be alone
___Don't care about appearance
___Fatigue, no energy
___Easily upset
___Inappropriate anger
___Undue fears
___Problems with appetite or sleep
___Total for section

Total Score: _____

CANDIDA QUESTIONNAIRE

How many times did you take antibiotics during the past two years? _____
How often do you eat sugar products? (chocolate/cookies/soft drink etc.) _____
Do you experience frequent sinus problems? Yes ___ No ___
Do you have sugar craving? Yes ___ No ___ or mental fog? Yes ___ No ___
Do you experience irregular bowel movement (constipation/diarrhea)? Yes__ No __
Do you experience periodic depression/severe mood swings/fatigue? Yes ___ No __
How old is your house? _____ Is it near a __pond, __lake, or __river? Yes __ No __
Did you notice any mold presence in your house or place of work? Yes ___ No ___

FEMALE QUESTIONNAIRE

Last menstrual cycle date: _____**Are you pregnant**? _____
General period duration: _____ days; **General monthly cycle**: _____ days
Details of last period: _____
(scanty/excessive, clotting, color, cramping, mood swing, breast tenderness/distention)

Do you usually experience PMS? Yes ___ No ___
If yes, what are the symptoms? _____

Were you on birth control pills/patches during the past 5 years? Yes ___ No ___

If yes, how many years have you been on it? _____

How often do you have yeast infection? _____

Did you do hysterectomy in the past? ____ If yes, when? _____ (ovary/uterus)

Do you have menopausal-like symptoms? _____
__ hot flashes __ feeling hot frequently __ irregular menstrual cycle
__ sleeping disorders __ mood changes __severe fatigue __vaginal dryness
__ low sex drive __ difficult to lose weight
__ symptoms are controlled with medication _____

Do you use hormone replacement therapy? _____
If yes, when did you start it? _____
List the hormones/dosage you are using _____

Do you have or suspect you have osteoporosis? _____
If yes, what medication/remedies are you using? _____

Do you have thyroid disorder? _____
If yes, what medication/remedies are you using? _____

Medication/Supplement Management Chart

Patient Name: _____ Date: _____

Product Name	Dosage	Description	Starting Date

CANCELLATION POLICY

Please be advised that our cancellation policies are strictly enforced.

In the event that you need to cancel and/or reschedule an appointment for a non-emergency reason, please call us or leave a message at **847-922-4156 or 954-682-1749 twenty four (24) hours in advance**. _____ (initial here)

Cancellation for emergency reasons is excluded from the above. Emergency reasons include accident/death in the family, sudden sickness of self or immediate family members, flight cancellations when travel etc. _____ (initial here)

Each patient is allowed **one non-emergency cancellation/reschedule per month**. _____ (initial here)

Two consecutive non-emergency cancellations will result in termination of Dr. Hong's services to you. _____ (initial here)

If your schedule is not always known in advance, you can schedule your appointments one week in advance only. However, you may not get the specific time you would like, due to other patients whose schedules are known. _____ (initial here)

Any violation of the above policy will result in $75 cancellation charge and/or termination of service. _____ (initial here)

I, _____, have read and agreed to comply with the above policy.

_____ (signature) Date: _____