**Monumental Allergy Relief**

Client Information and History

Name Date

Address City State \_\_\_Zip Code

Telephone Number

Email Address:

Age DOB Occupation/Employer

Who to reach in case of an emergency Contact #

How did you hear about our clinic?

Name of physician:

Medical History:

Current Medical Conditions:

Current Medications: Please list any prescription medications or over-the-counter medications you are taking.

What are your most important health concerns?

1. \_\_\_\_2. 3.

Please list tested or suspected allergies and related symptoms:

Foods

Seasonal

Drug / other

Are you pregnant? \_\_\_ Do you smoke?

Please read the Treatment Information form. Sign below when you have finished.

*Yes, I have read and understand the items listed on the Treatment Information form.*

Signature Date

(If under the age of 18, must be signed by Parent or Legal Guardian.)