Advanced Allergy Centers **603-894-0656**

Patient Information **Date: _____**

Name: _____
Address: _____
City: _____ State: _____
Zip_____
Home Phone: _____ Cell Phone:_____
Work Phone:_____
Email: _____

Gender: M F Age: __ Birth date: ___/___/___
Occupation: _____
In Case of Emergency Contact: _____
How did you hear about us?_____
Are you currently receiving health care? Please circle: Y N
If yes, name of physician: _____
Condition being treated: _____
_____
What are your most important health concerns?

1. _____
2. _____
3. _____

Please list tested or suspected allergies and related symptoms:
Foods _____
Seasonal _____
Drug/Other _____

Current Medications: Please list any prescription medications or over the counter medications you are taking. _____
Daily Dosage _____
Do you have a current medical condition(s) (e.g Epilepsy, Pregnant)? _____
_____
_____
_____

Do you smoke? Please circle: Y N

Please read the Allergy and Sensitivity description of Treatment form. Sign below when you have finished.

Yes, I have read and understand the items listed on the Allergy and Sensitivity description of Treatment form form.

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

Waiver and Release

I, _____ (the "Undersigned"), hereby consent to treatment at Advanced Allergy Centers, Salem, NH 03079

I understand that such procedures are non-invasive.

The Clinic and all of its employees assume no responsibility for medical conditions requiring the attention of a medical doctor, or necessary adjustments to prescribed medications during or after the completion of treatments.

I understand the unpredictable nature of allergies and related symptoms and that the clinic cannot guarantee any results. The clinic cannot guarantee that new allergies will not develop in the future. While we can treat most forms of allergies, some cases do not respond to the treatment.

I also understand that although extremely rare, the only known risk factor with allergy desensitization (including medical immunotherapy) is the possibility of increased sensitivity. I assume all responsibility for unpredictable immune reactions, which may lead to increased symptomatology. In this event, I agree to seek immediate medical attention.

I understand that the Clinic does not treat cases of anaphylaxis and I agree to fully disclose all information regarding any life-threatening allergies or allergies resulting in anaphylaxis.

- ❑ No, I do not have any life threatening allergies.
- ❑ Yes, I have the following allergies that may cause anaphylaxis:

I agree to pay the clinic the standard fee for any and all treatments administered.

IN WITNESS THEREOF, the undersigned executed the Agreement as at _____The day of _____ 20__

_____ _____

Signature of Undersigned Signature of Parent or Guardian

Allergy and Sensitivity description of Treatment Form

Advanced Allergy Centers treats the symptoms associated with allergies and sensitivities by reducing the biological stress caused by the offending substance. Cold Lasers are used along neurological points, which correspond with the major organ systems. During treatment, a digital signal of the substance you have tested positive for is introduced to the surface of the skin. Cold lasers with the digital signal then applied to the body to flip the body's response to a positive association and to reduce the stress load caused by the substance. The body associates the enhanced state with the substance, allowing for a more appropriate response.
The degree of stress on the organ systems, caused by an allergen, is proportional to the degree of the negative reaction. By easing the stress on the organ system involved, the related symptoms are also reduced, allowing for a positive conditioning effect.

- Advanced Allergy Centers does not diagnose allergies, sensitivities or intolerances.
- Advanced Allergy Centers does not test for allergies or sensitivities.
- Advanced Allergy Centers assesses what may be causing
- a stress to the body.
- Advanced Allergy Centers does not cure allergies.
- The treatment is highly effective in providing long-term relief from symptoms associated with allergies or sensitivities.
- I have read and understand the above and understand that everyone will respond differently and the treatment timeline may differ from one person to the next.

Signature: _____ Date:_____

BioEnergetic Stressor Testing Preparation

Drink 32 oz. of water the day before each scan.
Drink 16 oz. of water the day each scan.

Do not eat 1 hour before and 3 hours after the scan.

Do not take supplements 24 hours before the scan.
Continue prescription drugs, but best taken after the scan.

Take off jewelry, magnets and turn off all cell phones.

No alcohol 12 hrs. prior to scan.

Please wear a WHITE T-SHIRT without logo on back.

Please wear WHITE SOCKS.

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After a treatment it is best to avoid any strenuous activities. It is best to have all your other appointments (chiropractic adjustment, massages, acupuncture appointments) BEFORE this treatment. Also since we are working with the nervous and energy systems of the body please avoid any products that effect the energy systems. (Q link bracelets, necklaces etc....)

Our System Should not be used:

If you have a cold, you should not be treated, as your symptoms may become worse as your body is going through the detox .

- If the client has a cardiac pacemaker
- If the client is an organ transplant recipient
- If the client has been diagnosis with active cancer
- If the client has sub-dermal micro-tens or pain controlling device implanted within the body
- If the client is connected to a micro-tens or pain controlling device simultaneously to the biofeedback equipment
- If the client is electro-sensitive, or has ever been struck by lightening. Also, repeated testing can cause agitation and short term insomnia in some clients.
- It is not recommended to test a client more than once on the same day
- NOTE: Precautions should be taken when testing people with epilepsy
- **WE DO NOT TREAT ANAPHYLAXIS**