

Allergen Questionnaire

- _____ Dark circles under the eyes
- _____ Puffiness under the eyes
- _____ Sneeze often
- _____ Sniffing or runny nose
- _____ Severe food cravings or addictions
- _____ Extreme and frequent mood swings
- _____ Suffer from unnatural fatigue
- _____ Hot flashes or sweating for no apparent reason (non menopausal)
- _____ Craving for certain foods
- _____ Experience weight fluctuations of 4 to 5 lbs a day
- _____ Regular severe headaches or migraines
- _____ Regularly experience puffiness of face, ankles, or fingers
- _____ Dry throat, coughing
- _____ Skin rashes often
- _____ Have a history of food intolerance
- _____ Muscles aches
- _____ Heart beats strongly at times for no apparent reason