nourished
MEDSPA AND WELLNESS CENTER

**CONSENT FOR TREATMENT**

***Allergy Testing and Treatment***

**PURPOSE AND BACKGROUND**

As a patient of Nourished MedSpa and Wellness Center, I have requested allergy testing, which is used to evaluate for various allergies or antigens that I may react to. The procedure may require multiple sequential treatments. I understand that a skin test will be method of testing for allergic antibodies. A test consists of introducing small amounts of the suspected substance, or allergen, into the skin and noting the development of a positive reaction (which consists of a wheal, swelling, or flare in the surrounding area of redness). The results are read at 15 to 20 minutes after the application of the allergen. Interpreting the clinical significance of skin tests requires skillful correlation of the test results with my clinical history. Positive tests indicate the presence of allergic antibodies and are not necessarily correlated with clinical symptoms. I will be tested for important airborne allergens and possibly some foods. These include, trees, grasses, weeds, molds, dust mites, and animal dander and others. The skin testing generally takes 60 minutes. Prick (also known as percutaneous) tests are usually performed on my arms but may also be performed on my back. If I have a specific allergic sensitivity to one of the allergens, a red, raised, itchy bump (caused by histamine release into the skin) will appear on my skin within 15 to 20 minutes. These positive reactions will gradually disappear over a period of 30 to 60 minutes, and, typically, no treatment is necessary for this itchiness. Occasionally local swelling at a test site will begin 4 to 8 hours after the skin tests are applied. These reactions are not serious and will disappear over the next week or so. They should be measured and will be reported to my physician at my next visit. I understand that every individual is unique and it is very difficult to guarantee that I won't have a generalized allergic reaction that might require medical assistance.

I also consent to treatment of my allergies by either sublingual immunotherapy (oral) or subcutaneous immunotherapy (allergy shots). I am fully aware of the commitment required to successfully complete immunotherapy. The typical treatment is 3-5 years and sometimes longer. Frequently patients will start immunotherapy and only stay with it until they have symptomatic relief, only to be disappointed soon after when their symptoms return. Allergy serum vials are specially formulated compounded allergenic extracts, which are made for a specific individual. Therefore, an allergy vial made for one person cannot be given to another. Therefore, knowing this, I understand that I am financially responsible for 1) any allergy vials that are made specifically for my therapy, 2) any allergy vials that I have requested, and/or 3) any balance remaining from what insurance will not pay.

**PROCEDURE**

Skin testing will be administered at this facility with a medical physician or other health care professional present since occasional reactions may require immediate therapy. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the latter under extreme circumstances. Please let the physician and nurse know if you are pregnant or taking beta-blockers. Allergy skin testing may be postponed until after the pregnancy in the unlikely event of a reactions to the allergy testing and beta-blockers are medications they may make the treatment of the reaction to skin testing more difficult.

*Please note that these reactions rarely occur but in the event a reaction would occur, the staff is fully trained and emergency equipment is available.*

**RISKS AND COMPLICATIONS**

With allergy testing, as with any procedure that requires substances to be injected into the body, there is the possibility of adverse reactions. These generally are mild and include local reactions or mild systemic reactions. Although rare, more severe systemic reactions are possible.

**Local Reactions (common):**

- Burning or itching at the injection site
- Swelling or hives at the injection site
- Mild pain and tenderness at the injection site

**Mild Systemic Reactions (occasional):**

- Nasal congestion and/or runny nose with itching of ears, nose and or throat and/or sneezing occurring within two hours of the injection
- Itchy, watery or red eyes

**Severe Systemic Reactions include (rare):**

- Wheezing, coughing, shortness of breath and or airway swelling

- Generalized hives (welts)
- Swelling of the tissue around the eyes, the tongue, and or throat
- Stomach or uterine (menstrual-type) cramps
- Abnormalities of the heart beat
- Loss of ability to maintain blood pressure and pulse, possibly causing fainting
- Loss of consciousness, cardiac arrest and death

Allergy testing is contraindicated if a BETA BLOCKER medication is being taken. I hereby attest that I am not taking a beta blocker. Also, if I have a known allergy or reaction to glycerin, allergy testing or treatment must not be carried out.

**BENEFITS**
Allergy testing can aid in the identification of allergens that are causing your current nasal, sinus, eye, throat, ear or respiratory symptoms. Allergy testing can also identify the degree of sensitivity you may have to specific allergens. This information will aid your doctor or provider in developing an effective treatment plan to improve your allergy symptoms.

**ALTERNATIVES**
This is strictly a voluntary procedure. No treatment is necessary or required. You are not required to undergo allergy testing. You may suspect certain allergens are causing your symptoms and choose to avoid exposure to those allergens. You may also choose to take medications to treat your allergic symptoms without confirming your symptoms are caused by allergy.

**QUESTIONS**
This procedure has been explained to me by the staff of Nourished MedSpa and Wellness Center. I have had an opportunity to ask any questions and research the procedure to my satisfaction.

**CONSENT**
I understand that my consent and authorization for this procedure is strictly voluntary. I have already read and signed the Clinic's general consent and understand that it is still in effect. By signing this informed consent form, I hereby grant authority to Nourished MedSpa and Wellness Center and Dr. Jason Carter, MD (or other delegated medical providers for Nourished MedSpa and Wellness Center) to perform allergy testing and/or administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of my condition. For purposes of advancing medical education, I consent to the admittance of observers to the treatment room.

The nature and purpose of this procedure and the complications and side effects have been fully explained to me. Alternative treatments and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment. I agree to adhere to all safety precautions and instructions after the treatment. I have been instructed in and understand post treatment instructions and have been given a written copy of them. I understand that no refunds will be given for treatments received. No guarantee has been given or implied by anyone as to the results that may be obtained from this treatment.

I have read this informed consent and certify that I understand its contents in full. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I have had enough time to consider the information given me by my physician/practitioner and feel that I am sufficiently advised to consent to this procedure. I accept the risks and complications of the procedure. I certify that if I have any changes occur in my medical history I will notify Nourished MedSpa and Wellness Center immediately.

I hereby voluntarily consent to this procedure and release Nourished MedSpa and Wellness Center, medical staff, and all associated professionals from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age and am not under the influence of alcohol or drugs. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

| **Patient Name (please print)** | **Patient Signature** | **Date** |
|---|---|---|

| **Performed by (please print name and title)** | **Practitioner Signature** | **Date** |
|---|---|---|

Nourished MedSpa and Wellness Center
Allergy Patient Information

Date: _____ Name: _____ Date of Birth: _____

Circle any of the following symptoms you are experiencing:

| | | | | |
|---|---|---|---|---|
| Stuffy nose | Runny nose | Sneezing | Nosebleeds | Eczema |
| Swelling | Scratchy throat | Wheezing | Itching | Loss of smell |
| Sniffing | Red/itchy eyes | Dark circles | Puffy eyes | Post nasal drainage |
| Throat clearing | Swelling | Dry cough | Rash | Hives |
| Sinus pain | Headaches | Ear pain | Unexplained fatigue | |
| Other: | | | | |

Circle which of the following areas are affected:

| | | | | |
|---|---|---|---|---|
| Eyes | Nose | Ears | Throat | Lungs |
| Skin | General | | | |
| Other: | | | | |

How would you describe the severity of your symptoms?

| | | |
|---|---|---|
| Mild | Moderate | Severe |

How long do the symptoms last?

| | | |
|---|---|---|
| <1 week | Seasonal | Year-round |

Have you ever been diagnosed with asthma or bronchitis? ❑ Yes ❑ No

When are your symptoms worst?

| | | | | |
|---|---|---|---|---|
| Year round | January | February | March | April |
| May | June | July | August | September |
| October | November | December | | |

Which of the following seems to bother you or trigger/cause the above symptoms?

| | | | | |
|---|---|---|---|---|
| Grass | House dust | Perfumes | Nervousness | Cats |
| Leaves | Latex (rubber) | Foods | Pollen | Dogs |
| Cosmetics | Mold & mildew | Pollution | Odors | Weather change |
| Hay | Cold air | Smoke | Insecticides | Other animals |
| Exercise | Basements | Aerosol sprays | Clothing | Metals |
| Alcoholic drinks | Insect bites/stings | Describe reaction: | | |

Are symptoms better away from home? ❑ Yes ❑ No
If yes, when? _____

Have you ever had an allergy skin test or blood test? ❑ Yes ❑ No
If yes, results: _____

Have you ever had allergy injections? ❑ Yes ❑ No
If yes, when? _____

Have you received cortisone (prednisone, methylprednisolone, etc.) drugs? ❑ Yes ❑ No
If yes, when? _____ How much? _____

Are you on allergy medications? ❑ Yes ❑ No

| Name of medication | Dosage | For how long? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Regarding possible food allergies, do you experience any of the following: (check all that apply)

| | | |
|---|---|---|
| ❑ Bloating after eating | ❑ Constipation | ❑ Indigestion |
| ❑ Stomach pain | ❑ Diarrhea | ❑ Vomiting |
| ❑ Nausea | ❑ Upset stomach | ❑ Tingling of the mouth |

**ENVIRONMENTAL SURVEY**

1. How long have you lived in your house/apartment? _____
2. Do you live in a ❑ House ❑ Apartment/duplex ❑ Condominium/townhouse
3. Approximately how old is your home? _____
4. Do you live in ❑ City ❑ Suburbs ❑ Rural area
5. Do you have a basement? ❑ Yes ❑ No
6. Type of heating: ❑ hot air ❑ steam (radiator) ❑ electric ❑ hot water (baseboard)
7. Do you have: ❑ Wood /coal stove or fireplace ❑ Humidifier ❑ Dehumidifier ❑ Air cleaner
8. Number of pets (indoor or outdoor) ____Cats ____Dogs ____Birds ____Other _____
9. Are there any tobacco smokers in your home? ❑ Yes ❑ No
10. Is your bedroom in the basement? ❑ Yes ❑ No
11. Do you have allergy-proof encasing for pillow or mattress? ❑ Yes ❑ No
12. What type of pillows do you have? _____
13. What type of comforter do you have? _____
14. What type of floor covering do you have in your bedroom?

    ❑ Wall to wall ❑ Area rug ❑ Animal skin ❑ Bare floor

15. How old is your mattress?_____ What's inside your mattress? (i.e. cotton / synthetic fibers)_____
16. Do you have air conditioning? ❑ Yes ❑ No

    If yes, is it: ❑ Window unit ❑ Central
17. Do you have HEPA filters on your air conditioning? ❑ Yes ❑ No
18. Are your home filters changed every 3 months? ❑ Yes ❑ No
19. Do you have problems with roaches or mice? ❑ Yes ❑ No
20. Do you have water leaks, mold contamination? ❑ Yes ❑ No
21. Is your home/apartment excessively humid? ❑ Yes ❑ No
22. Do you experience runny nose or sneezing in response to eating? ❑ Yes ❑ No
23. Do you experience runny nose or sneezing in response to strong odors? ❑ Yes ❑ No
24. Do you experience runny nose or sneezing in response to exercise? ❑ Yes ❑ No
25. Do you experience runny nose in response to emotional upset? ❑ Yes ❑ No
26. Have you had your tonsils or adenoids removed? ❑ Yes ❑ No
27. Have you had ear, nose or sinus surgery? ❑ Yes ❑ No

**FAMILY MEMBERS WITH DIAGNOSED ALLERGIES**

| | Child | Sibling | Parent | Grandparent |
|---|---|---|---|---|
| Asthma | | | | |
| Eczema | | | | |
| Seasonal allergies | | | | |
| Sinus problems | | | | |

Do you smoke? ❑ Yes ❑ No
If yes, how much?_____

Have you smoked in the past? ❑ Yes ❑ No
How long ago did you stop? _____

How many years did you smoke? _____

**AGE WHEN ISSUES WERE FIRST OBSERVED**

□ Infant (Age 0 – 2)
□ Child (Age 3 – 5)
□ Child (Age 6 – 12)
□ Adolescent (Age 13 – 18)
□ Adult (Age 19 – 25)
□ Adult (Age 26 – 40)
□ Adult (Age >40)

| SKIN | EYE |
|---|---|
| □ Hives<br>□ Rashes<br>□ Itching<br>□ Eczema<br>□ Swelling<br>□ Sores<br>□ Once had rashes in the bends of knees or elbows<br>□ Above are worse during known pollen seasons<br>□ Above are worse with animal exposure<br>□ Skin problems are rare<br>□ Skin problems are chronic<br>□ none | □ Itching<br>□ Excessive Watering<br>□ Redness<br>□ Swelling<br>□ Above are worse during pollen seasons<br>□ Above are worse with animal exposure<br>□ Tobacco smoke/chemical especially makes me feel worse<br>□ none |
| **EAR** | **NASAL** |
| □ Itching<br>□ Blocking, Fullness or Popping<br>□ Pain<br>□ Frequent Ear Infections<br>□ Hearing Loss<br>□ Ear Tubs<br>□ Ringing in Ears | □ Itching<br>□ Sneezing<br>□ Running Nose-Clear Discharge<br>□ Frequent Nose Blowing<br>□ Above are worse during pollen exposure<br>□ Above are worse with animal exposure<br>□ Runny Nose – Cloudy Discharge<br>□ Stuffiness<br>□ Post Nasal Drip<br>□ Frequent sinus Infections<br>□ Nasal Obstruction<br>□ Loss of Smell |
| **THROAT & MOUTH** | **GASTROINTESTINAL** |
| □ Itching of Throat or Mouth<br>□ Frequent Sore Throat<br>□ Frequent Laryngitis<br>□ Frequent Tonsillitis<br>□ Mouth Sores<br>□ Swelling of the Tongue or Mouth<br>□ None | □ Nausea and Vomiting<br>□ Diarrhea<br>□ Gas<br>□ Abdominal Pain<br>□ Re-taste Foods<br>□ Constipation<br>□ Stomach pains or Cramps<br>□ Heart Burn<br>□ none |
| **EMOTIONS** | **BONE & JOINT** |
| □ Mood Swings<br>□ Anxiety/Fear/Nervousness<br>□ Anger/Irritability/Aggressiveness<br>□ Argumentative<br>□ Depressed | □ Joint or Bone Pain<br>□ Muscle Pain<br>□ Redness or Swelling of Joints<br>□ Joint Stiff, Limited Motion |

| LUNGS | HEART |
|---|---|
| □ Chest Congestion<br>□ Shortness of Breath<br>□ Difficulty Breathing<br>□ Wheezing<br>□ Dry Coughing<br>□ Wet Coughing<br>□ Emphysema<br>□ Frequent Bronchitis<br>□ Recurring Pneumonia | □ Chest Pain<br>□ Irregular/Skipped Heartbeat<br>□ Rapid /Pounding Heartbeat<br>□ Chest Pain<br>□ High Blood Pressure<br>□ none |
| **WEIGHT** | **ADRENAL** |
| □ Binge eating/drinking<br>□ Excessive Weight<br>□ Compulsive Eating<br>□ Craving Certain Foods<br>□ Water Retention<br>□ Want To Lose 10 lbs +<br>□ Cannot Lose weight no matter what I eat or do | □ Crave for Salty, Fatty, High Protein foods<br>□ Get Dizzy when Stand Up Quickly<br>□ I am Tired when I Awake in Morning<br>□ Frequent Sore Throat &/or Laryngitis<br>□ Reduced Sex Drive<br>□ Feeling Overwhelmed, Depressed<br>□ Irregular Sleep/Insomnia |
| **THYROID** | **I FEEL BETTER** |
| □ Weight gain/ Unable to lose weight with diet/exercise<br>□ Fatigued, exhausted<br>□ I feel Depressed, no motivation, moody<br>□ Dry Skin<br>□ Poor Memory<br>□ Constipation<br>□ Lost outer edge of Eye Brow<br>□ Hair is Course, dry, brittle, falling out | □ After Shower or Bath<br>□ In Air Conditioning<br>□ Indoors<br>□ During or After Physical Activity<br>□ After Taking Antihistamines<br>□ With Allergy Shots<br>□ When Away from Home<br>□ When at Home |
| **I FEEL WORSE** | |
| □ When exposed to tobacco smoke<br>□ With yard work, cut grass, leaves, hay or barns<br>□ When sweeping or dusting the house<br>□ In areas with mold or mildew<br>□ In air conditioning<br>□ In fields or in the country<br>□ Tobacco smoke bothers me more than anything else<br>□ Don't know | |

**FOODS THAT CAUSE DISCOMFORT WHEN CONSUMED:**

| WITHIN 1-2 HOURS | WITHIN 3-24 HOURS |
|---|---|
| □ Eggs<br>□ Milk<br>□ Beef<br>□ Corn<br>□ Wheat / gluten / bread<br>□ Soybean<br>□ Peanut<br>□ MSG<br>□ Pork<br>□ Fatty foods<br>□ Fish<br>□ Shellfish<br>□ Orange or Other Citrus<br>□ Potato<br>□ Tomato<br>□ Yeast<br>□ Chocolate<br>□ Coffee or Tea<br>□ Other: _____ | □ Eggs<br>□ Milk<br>□ Beef<br>□ Corn<br>□ Wheat / gluten / bread<br>□ Soybean<br>□ Peanut<br>□ MSG<br>□ Pork<br>□ Fatty foods<br>□ Fish<br>□ Shellfish<br>□ Orange or Other Citrus<br>□ Potato<br>□ Tomato<br>□ Yeast<br>□ Chocolate<br>□ Coffee or Tea<br>□ Other: _____ |

**LEVEL OF GI DISCOMFORT:**

Headaches Swelling of mouth Upset stomach Vomiting Diarrhea

**CHEMICALS I'M SENSITIVE TO:**

□ Insecticides & Pesticides
□ Paints & Household Cleaners
□ Perfumes & Cosmetics
□ Gasoline or Automobile Exhaust
□ Stove or Furnace Emissions
□ The Smell of New Fabrics or Fabric Stores
□ Chemicals in the Workplace

Have you ever had sinus x-rays? (check one) □Yes □No If yes, please explain: _____
_____
_____

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or complications from your treatment that may be irreversible and/or dismissal from the practice. The treatments I receive here are voluntary and I release this institution, all employees and contractors from liability and assume full responsibility thereof.

_____ Date: _____
Patient Signature

**PRE-TREATMENT INSTRUCTIONS**

***Allergy testing Procedure***

1. No prescription or over the counter oral antihistamines should be used 5 days prior to scheduled skin testing. These include cold tablets, sinus tablets, hay fever medications, or oral treatments for itchy skin, over the counter allergy medications, such as Claritin, Zyrtec, Allegra ,Actifed, Dimetapp, Benedryl, and many others. Prescription antihistamines such as Clarinex and Xyzol should also be stopped at least 5 days prior to testing. If you have any questions whether or not you are using an antihistamine, please ask the nurse or Dr. Carter. In some instances, a longer period of time off these medications may be necessary.

2. You should discontinue your nasal and eye antihistamine medications, such as Patanase, Pataday, Astepro, Optivar, or Astelin at least 2 days before the testing. In some instances, a longer period of time off these medications may be necessary. If you have any questions whether or not you are using an antihistamine, please ask the nurse or Dr. Carter. In some instances, a longer period of time off these medications may be necessary.

3. Medications such as over the counter sleeping medications (e.g. Tylenol PM) and other prescribed drugs, such as amytriptyline hydrochloride (Elavil), hydroxyzine (Atarax), doxepin (Sinequan), and imipramine (Tofranil) have antihistaminic activity and should be discontinued at least 2 weeks prior to receiving skin test after consultation with Dr. Carter.

4. You may continue to use your intranasal allergy sprays such as Flonase, Rhinocort, Nasonex, Nasacort, Omnaris, Veramyst and Nasarel.

5. Asthma inhalers (inhaled steroids and bronchodilators), leukotriene antagonist s (e.g. Singulair, Accolate) and oral theophylline (Theo-Dur,T-Phyl, Uniphyl, Theo-24, etc.) do not interfere with skin testing and should be used as prescribed.

6. Most drugs do not interfere with skin testing but make certain that your physician and nurse know about every drug you are taking (bring a list if necessary).

7. Please have your normal meal or snack prior to testing.

8. Wear short sleeves on the day of the testing. A tank top or camisole would be ideal.

9. Do not place lotion on your body the day of the testing.

10. Plan on being in the office for 1-2 hours.

We request that you do not bring small children with you when you are scheduled for skin testing unless they are accompanied by another adult who can sit with them in the reception room.

Please do not cancel your appointment since the time set aside for your skin test is exclusively yours for which special allergens are prepared. If for any reason you need to change your skin test appointment, please give us at least 48 hours' notice, due to the length of time scheduled for skin testing, a last-minute change results in a loss of valuable time that another patient might have utilized.

*Please contact our office at 903-357-5108 with any questions or concerns.*

**POST-TREATMENT INSTRUCTIONS**

***Allergy Testing Procedure***

**Seek immediate medical attention for any of the following signs or symptoms:**

- Itching, a rash, hives that spread over your body
- Trouble breathing, swelling in your mouth or throat, or wheezing
- Feeling you are going to faint

Inform our office immediately if a reaction has occurred. If immediate care is needed, call Dr. Carter, proceed to the nearest emergency room, or call 911.

You should know by the time you leave the office what you are allergic to. Now, you must decide if you want treatment. We offer two forms of allergy treatment: oral drops or allergy shots.

**ORAL THERAPY (DROPS)**

This is a once daily under-the-tongue therapy that works the same as subcutaneous immunotherapy. There are some specific differences between the shots and drops. The allergy drops are not covered by any insurance and is a cash pay product. The allergy drops are prescribed in 12 week increments and should be taken daily. You can convert back and forth from shot-to-drop or drop-to-shot. The 4-vial starter set takes 3 months to complete. Your single vial maintenance treatment lasts 3 months and thus requires four (4) vials per year for maximal therapy and benefit. **Maintenance vials are not reordered automatically**. Make sure to ask Dr. Carter to reorder your next set of therapy with at least 14 days' notice to ensure getting your therapy on time. Please notify the office if you have any concerns about tolerability of your therapy; common side-effects may include tingling of the lips or tongue, mild swelling of the tissue beneath the tongue or mild abdominal discomfort. Any time you are experiencing heightened allergy symptoms or illness, contact our office for instructions or discontinue your treatment until advised by Dr. Carter. Insurance will not be filed for the drops as it is not a covered service.

**SUBCUTANEOUS THERAPY (SHOTS)**

This is a once per week injection administered in the clinic.

*Please contact our office at 903-357-5108 with any questions or concerns. If you have an emergency or urgent pressing clinical issue, call Dr. Carter at 903-818-3467. Texting is the best way to reach Dr. Carter.*

Please make an appointment for follow-up and reassessment in 4 weeks. In the meantime, you can do the following:

- Take a bath or shower at night to wash off any antigens/pollen that may have accumulated during the day
- Thoroughly clean your home including wiping down all surfaces. Look for any mold in damp areas. Don't forget to look under the kitchen sink for mold. Get leaks fixed; seal holes; declutter. Consider a dehumidifier.
- Wash curtains and wipe down blinds or shades.
- Use a HEPA filter in your air conditioning and vacuum cleaner. Vacuum at least once weekly.
- Wash bedsheets and replace your pillows with hypoallergenic pillows. Cover mattress and pillows with dust mite covers
- Put two doormats at each entryway, or have family and guests remove their shoes when they enter
- Consider a room air filter. Make sure you get one that doesn't produce ozone, a gas that is irritating to people with allergies

**Patient Name (please print)** **Patient Signature** **Date**