==
Pre-treatment
HEALTH QUESTIONNAIRE

Please complete the following Health Questionnaire and bring with you to the appointment.
IMPORTANT: Prior to your treatment you will need to avoid alcohol and coffee for at least 6 hours before and after.

- First Name Last Name
- Address1
- Address2
- City
- Postal Code
- Email

Country:
Time Zone:

- Phone
- Date of birth: ____ / ___ / __ __ __ __

Day / month / year
Section 1

- Do you have a heart pacemaker?* __Yes __No __Not applicable

- Do you have a hearing aid?* __Yes __No __ Not applicable

- Any metal implants?* __Yes __No __Not applicable
- For women – are you pregnant?* __Yes __No __Not applicable

- Have you had a transplant?* __Yes __No __Not applicable

- What's your primary reason for seeking bioresonance?*
- When did this first begin?
- What was the initial cause?
- What makes it worse?
- What makes it better?

- This problem affects your?*

o physical well-being
o emotional well-being o mental well-being
o walking
o standing
o sitting
o lying down

o sleep
o work life
o exercise
o social life
o personal relationships o sexual life

• How are your energy levels?
o Great
o OK
o Fluctuating
o Poor
o What's energy?

- Do you have a low point during the day? __Yes __No
- Do you have a high point during the day? __Yes __No
- Do you sleep well?* __Yes __No
- Do you drink tea or coffee?* __Yes __No
- Do you drink alcohol?* __Yes __No
- Do you smoke?* __Yes __No
- Signs / Symptoms

• General problems, check all that apply
o Fatigue
o lack of energy
o sudden energy drops o shortness of breath
o poor sleep
o insomnia
o nightmares
o night sweats
o snoring
o travel sickness
o unusual perspiration
o no perspiration at all
o sweat easily
o hair loss
o unintended weight loss o unintended weight gain o overweight
o underweight
o fluid retention
o heavy drinking
o smoking
o sugar cravings
o sugar causing neg symptoms o poor appetite
o always hungry

o always thirsty
o peculiar tastes
o excessive phlegm
o tumors
o cancer
o none of the above

• Immune system, check if you have ever had any of the following*
o rheumatic diseases
o arthritis
o fibromyalgia
o chronic fatigue
o frequent colds
o ulcerative colitis
o morbus crohn
o coeliac disease
o hay fever
o chronic low grade fever
o swollen glands/lymph nodes o measles
o mumps
o chicken pox
o shingles
o scarlet fever
o multiple sclerosis
o chronic fatigue syndrome o syphilis
o gonorrhiea
o herpes
o HIV/AIDS
o none of the above

• Digestive system: check if you have had any of these o constipation
o diarrhia
o dark stools
o very smelly stools
o blood in stools
o mucous on/in stools
o irritable bowel syndrome o intestinal cramping
o loss of appetite
o bloating
o gas
o belching
o tiredness after eating

o no appetite in the morning
o hiccups, abdominal cramping / pain
o food allergies or intolerances
o abdominal distension
o heartburn
o acid regurgitation
o vomiting
o stomach or duodenal ulcers
o gastritis
o lack of stomach acid
o pancreatitis
o gallstones
o hepatitis
o liver cirrhosis
o gallbladder disease
o laxative use
o hemorrhoids
o none of the above

• Head: check all that you suffer from or have suffered
from*
o headaches
o migraines
o dizziness / vertigo
o concussion
o loss of hair
o premature greying of hair o none of above

• Mental / emotional / nervous system: check all that you suffer from or have suffered from*
o moodiness
o irritability
o excessive worrying o poor memory
o dyslexia
o anxiety
o fearfulness
o phobias
o nervousness
o poor concentration o stuttering
o confusion
o depression
o short temper
o outbreaks of rage o seizures
o epilepsy
o bipolar disorder

o OCD
o ADD
o ADHD
o drug addiction
o alcoholism
o abuse survivor
o none of the above

• Mouth*
o dry mouth / throat
o metallic / bitter / sour / foul taste in mouth o halitosis (bad breath)
o bad teeth
o bleeding gums
o abscesses
o mouth ulcers
o inflammations
o cold sores
o jaw joint pain
o cracking jaw joint
o grinding teeth
o missing teeth
o root canal treatment
o amalgam / gold fillings
o crowns
o inlays
o bridges
o false teeth
o braces
o none of the above

• Ears: check which apply*
o poor hearing
o deafness
o tinnitus (ringing in ear) o itching of ear canal
o frequent ear infections o ear aches
o none of above

• Nose: check which apply*
o poor sense of smell
o congested nose
o runny nose / clear discharge o yellow/green phlegm
o recurring sinus infections o polyps
o post nasal drip

o nose bleeds
o cold sores
o none of above
• Eyes and Vision: check which apply*
o poor vision
o blurred vision o dry eyes
o itchy eyes
o red eyes
o floating spots in vision
o wind sensitivity
o light sensitivity
o cataracts
o none of above

• Skin:*
o eczema
o acne (pimples) o dry skin
o oily skin
o itchy skin
o neurodermatitis
o psoriasis
o warts
o abscesses
o rash
o fungal infection
o athlete's foot
o nail infection
o none of the above

• Respiratory system:*
o cough
o shortness of breath o asthma
o wheezing
o bronchitis
o pneumonia
o frequent colds
o frequent tonsillitis / sore throat / strep throat o emphysema
o lung abscesses
o tuberculosis
o whooping cough o coughing blood o none of above

• Urinary system:*
o UTIs (urinary tract infections) o kidney stones
o incontinence

o pain when urinating
o difficulty urinating
o blood in urine
o too frequent urgent urination o wake at night to urinate
o urinary reflux
o bladder weakness
o none of above

• Heart and circulation:
o fast pulse (resting pulse rate over 100 bpm) o slow pulse (less than 60 bpm)
o palpitations
o heart arrhythmia
o chest pain or tightness
o high blood pressure
o low blood pressure
o stroke
o constantly feeling hot
o constantly feeling cold
o cold hands
o cold feet
o burning hands
o burning feet
o afternoon/evening fevers
o constant low-grade fever
o blushing
o hot flushes
o anemia
o dizziness when standing up
o fainting spells
o bruise easily
o numbness or tingling sensations o none of above

• Hormone system:*
o diabetes
o low blood sugar level
o enlarged thyroid
o hypothyroidism
o none of above
• I am female: __Yes __No

• Muscles, joints and bones:
o injuries to joints
o injuries to bones
o injuries to muscles

o injuries to ligaments or sinews o injuries to tailbone
o injuries to spine
o injuries to neck
o injuries to skull
o pain in joints
o pain in bones
o pain in muscles
o pain in ligaments or sinews o pain in tailbone
o pain in spine
o pain in neck
o pain in skull
o muscle cramps
o limited range of motion o tight neck/shoulders
o lower back pain
o lumbar prolapse / herniated disc o sciatica, weak legs
o leg length difference o RSI/OOS
o none of above

- The following things can affect one's health, even long after they are over, list which apply
Please check which apply in the past or now
- 1. Any pregnancy or birth complications (ask your mother if possible)* __Yes __No

- 2. Issues that affect the whole family: Absence or illness of family members, addictions of any kind,psychological illness, (attempted) suicide, physical, sexual or emotional abuse, emotional neglect, etc.* __Yes __No

- 3. Unusual course of children's diseases and complications from vaccinations* __Yes __No
- 4. Any serious or recurring disease* __Yes __No
- 5. Psychological issues, traumatic or unsettling experiences* __Yes __No
- 6. Accidents (including sports accidents)* __Yes __No
- 7. Surgeries and other invasive procedures* __Yes __No

- 8. Recreational drug use (past or present)*__Yes __No
- Your close family's medical history:
Please indicate if any of your family members have or had any of the following conditions:
- Allergies* __Yes __No __I don't know

- heart disease* __Yes __No __I don't know
- Arthritis* __Yes __No __I don't know
- chronic fatigue diabetes* __Yes __No __I don't know
- Parasites* __Yes __No __I don't know
- Tuberculosis* __Yes __No __I don't know
- Hepatitis* __Yes __No __I don't know

- Cancer* __Yes __No __I don't know
- hypo/hyperthyroid* __Yes __No __I don't know
- Epilepsy* __Yes __No __I don't know
- Seizures* __Yes __No __I don't know
- Additional things you wish to tell us: ____

____

____