CONFIDENTIAL –FOR MEDICAL USE ONLY

BIOMEDIC ASSESSMENT FORM

FORENAME..SURNAME..TODAY'S DATE.............................REF.NO...................

DATE OF BIRTH................................OCCUPATION...EMAIL..

ADDRESS………POSTCODE…………………………..

TEL. DAYTIME…………………………………..TEL. EVENING……………………………………..MOBILE…………………………………REFERRAL……………………………

I AM — *SINGLE/MARRIED/DIVORCED/SEPARATED/WIDOWED/WITH PARTNER*
I LIVE WITH — *SPOUSE/PARTNER/FRIEND/CHILDREN/PARENTS/ON MY OWN/*
I AM CURRENTLY — *EMPLOYED/UNEMPLOYED/SELF EMPLOYED*

MY CURRENT **HEALTH CONCERN** IS/ARE:

………

………

PREGNANCY / BIRTH

DID **YOUR MOTHER'S PREGNANCY** PROGESS TO FULL TERM IN A HEALTHY MANNER; IF NOT EXPLAIN: ◊ YES ◊ NO ……………………………

………..

WAS IT FOLLOWED BY A NORMAL VAGINAL DELIVERY, AND IF NOT, PLEASE EXPLAIN: ◊ YES ◊ NO …………………………………………………………

………..

HAVE YOU BEEN BREASTFEED; AND IF YES; FOR HOW LONG? ◊ YES, FOR ……………………….d/m/y ◊ NO

MEDICAL HISTORY

PLEASE LIST ALL **DISEASES, PHYSICAL TRAUMAS & OPERATIONS** THAT YOU HAVE HAD AND YOUR **AGE** WHEN THEY OCCURRED:

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PLEASE TICK FOR THE **PAST** OR **CURRENT TENDENCY** TO EXPERIENCE THE FOLLOWING DYSFUNCTIONS REPETATIVELY:

SKIN IRRITATION	◊ NO	◊ YES; IN THE PAST	◊ YES; CURRENTLY
MUSCLES & JOINTACHES/PAINS	◊ NO	◊ YES; IN THE PAST	◊ YES; CURRENTLY
EXCESSIVE SWEATING	◊ NO	◊ YES; IN THE PAST	◊ YES; CURRENTLY
INDIGESTION	◊ NO	◊ YES; IN THE PAST	◊ YES; CURRENTLY
BLOATING/FLATULENCE	◊ NO	◊ YES; IN THE PAST	◊ YES; CURRENTLY
CONSTIPATION	◊ NO	◊ YES; IN THE PAST	◊ YES; CURRENTLY
DIARRHOEA	◊ NO	◊ YES; IN THE PAST	◊ YES; CURRENTLY

APPETITE OSCILLATIONS	◊ NO	◊ YES; IN THE PAST	◊ YES; CURRENTLY
BREATHING DIFFICULTIES	◊ NO	◊ YES; IN THE PAST	◊ YES; CURRENTLY
PALPITATION	◊ NO	◊ YES; IN THE PAST	◊ YES; CURRENTLY
FREQUENT URINATION	◊ NO	◊ YES; IN THE PAST	◊ YES; CURRENTLY
TIREDNESS	◊ NO	◊ YES; IN THE PAST	◊ YES; CURRENTLY
EMOTIONAL DIFFICULTIES	◊ NO	◊ YES; IN THE PAST	◊ YES; CURRENTLY
INSOMNIA	◊ NO	◊ YES; IN THE PAST	◊ YES; CURRENTLY
FREQUENT INFECTIONS	◊ NO	◊ YES; IN THE PAST	◊ YES; CURRENTLY

OTHERS……
………

FEMALES ONLY

AGE AT ONSET OF **MENSTRUATION**? ……………………………………………………………………………………………
AGE AT ONSET OF **MENOPAUSE?** ……………………………………………………………………………………………
HAVE YOU TAKEN **ORAL CONTRACEPTIVE PILLS?** ◊ NO ◊ YES, HOW LONG? ……………………………………………
HAVE YOU TAKEN **HORMONE REPLACEMENT THERAPY (HRT)?** ◊ NO ◊ YES, HOW LONG? ……………………………………………
HAVE YOU EVER **EXPERIENCED** ANY OF THE FOLLOWING? (PLEASE TICK)

IRREGULAR PERIODS	◊	UTERINE FIBROIDS	◊	EXTRAUTERINE PREGNANCY	◊
ABSENCE OF PERIOD	◊	NORMAL BIRTH	◊	ECLAMPSIA	◊
MENORRHAGIA (HAEMORRHAGE)	◊	MISCARRIAGE	◊	DIABETES IN PREGNANCY	◊
INFECTION IN REPRODUCTIVE ORGANS	◊	ABORTION	◊	PLACENTA PRAEVIA	◊
OVARIAN CYST	◊	STILL BIRTH	◊	INFERTILITY	◊
ENDOMETRIOSIS	◊	PREMATURE BIRTH	◊	CERVICAL DYSPLASIA	◊

FAMILY HISTORY

PLEASE FILL IN THE RELAVANT MEDICAL DETAILS OF **YOUR FAMILY MEMBERS.**

DISEASES:			**FAMILY MEMBER**
MALIGNANT DISEASES	◊ NO	◊ YES	…………………………………………
CONGENITAL DISEASES	◊ NO	◊ YES	…………………………………………
HIGH BLOOD PRESSURE	◊ NO	◊ YES	…………………………………………
HEART DISEASE	◊ NO	◊ YES	…………………………………………
BLOOD DISEASE	◊ NO	◊ YES	…………………………………………
LUNG DISEASE	◊ NO	◊ YES	…………………………………………
STOMACH DISEASE	◊ NO	◊ YES	…………………………………………
BOWEL DISEASE	◊ NO	◊ YES	…………………………………………
LIVER/GALL BLADDER DISEASE	◊ NO	◊ YES	…………………………………………
KIDNEY DISEASE	◊ NO	◊ YES	…………………………………………
ARTHRITIS	◊ NO	◊ YES	…………………………………………
BONE DISEASE	◊ NO	◊ YES	…………………………………………
DIABETES	◊ NO	◊ YES	…………………………………………
THYROID PROBLEM	◊ NO	◊ YES	…………………………………………
STROKE	◊ NO	◊ YES	…………………………………………
MULTIPLE SCLEROSIS	◊ NO	◊ YES	…………………………………………
EPILEPSY	◊ NO	◊ YES	…………………………………………
PSYCHIATRIC DISEASE (DEPRESSION ETC…)	◊ NO	◊ YES	…………………………………………

OTHERS, PLEASE SPECIFY:

……

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PLEASE GIVE **NAME; DOSAGE & FREQUENCY** OF ANY CURRENT **MEDICATION** AND WHEN YOU STARTED TAKING IT:

CURRENT MEDICATION:	**STARTED:**
1. ………………………………………………………………	…………………………………………
2. ………………………………………………………………	…………………………………………
3. ………………………………………………………………	…………………………………………
4. ………………………………………………………………	…………………………………………
5. ………………………………………………………………	…………………………………………

IF YOU ARE CURRENTLY RECEIVING / PRACTICING ANY **ALTERNATIVE THERAPY(S),** PLEASE SPECIFY.

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LIST **ANY REMEDIES; SUPPLEMENTS; VITAMINS OR HERBS** YOU ARE TAKING **AND WHEN** YOU STARTED TAKING IT:

1. …………………………………………………………………………………………… ……………………………………………………
2. …………………………………………………………………………………………… ……………………………………………………
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DENTAL HISTORY

HAVE YOU GOT?

BLEEDING GUMS	◊ NO	◊ YES
AMALGAMS (SILVER FILLINGS)	◊ NO	◊ YES; HOW MANY ………………………
ROOT CANAL PROCEDURE DONE	◊ NO	◊ YES; HOW MANY ………………………
PARADENTOSIS (RECEDING GUMS)	◊ NO	◊ YES

IF ANY OTHER DENTAL WORK HAS BEEN DONE, PLEASE LIST

……… AGE……………
……… AGE…………..
……… AGE…………..

ALLERGIES / SENSITIVITIES / DEFICIENCIES / TOXICITIES

DO YOU HAVE ANY **MEDICALLY CONFIRMED** ALLERGIES? ◊ NO ◊ YES, PLEASE LIST

……

DOES ANY OTHER SUBSTANCES TRIGGER THE EXPERIENCE OF ALLERGY – LIKE SYMPTOMS? ◊ NO ◊ YES, PLEASE LIST

……

DO YOU HAVE ANY FOOD GRAVINGS? ◊ NO ◊ YES, PLEASE LIST

……

HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING?

AGRICULTURAL CHEMICALS	◊ NO	◊ YES	
INDUSTRIAL/WORKPLACE CHEMICALS	◊ NO	◊ YES	
CIGARETTE SMOKING	◊ NO	◊ YES	HOW MUCH……………………………. HOW LONG……………………
ALCOHOL USE	◊ NO	◊ YES	HOW MUCH……………………………. HOW LONG……………………
RECREATIONAL DRUGS	◊ NO	◊ YES	HOW MUCH……………………………. HOW LONG……………………

OTHER, PLEASE EXPLAIN………

ARE YOU CURRENTLY ON A NORMAL DIET, VEGETARIAN DIET, VEGAN DIET, WEIGHT MANAGEMENT DIET – PLEASE SPECIFY

………

PLEASE TICK YOUR **INTAKE** OF THE FOLLOWING FOODS AND DRINKS.

DAIRY	SERVINGS…..	DAILY ◊	WEEKLY ◊	OCCASIONALLY ◊	NEVER ◊
WHEAT	SERVINGS…..	DAILY ◊	WEEKLY ◊	OCCASIONALLY ◊	NEVER ◊
VEGETABLES	SERVINGS…..	DAILY ◊	WEEKLY ◊	OCCASIONALLY ◊	NEVER ◊
RED MEAT	SERVINGS…..	DAILY ◊	WEEKLY ◊	OCCASIONALLY ◊	NEVER ◊
SPICY FOOD	SERVINGS…..	DAILY ◊	WEEKLY ◊	OCCASIONALLY ◊	NEVER ◊
SALTY FOOD	SERVINGS…..	DAILY ◊	WEEKLY ◊	OCCASIONALLY ◊	NEVER ◊
SUGARY FOOD	SERVINGS…..	DAILY ◊	WEEKLY ◊	OCCASIONALLY ◊	NEVER ◊
FRUIT	SERVINGS…..	DAILY ◊	WEEKLY ◊	OCCASIONALLY ◊	NEVER ◊
WATER	AMOUNT…..	DAILY ◊	WEEKLY ◊	OCCASIONALLY ◊	NEVER ◊
COFFEE	AMOUNT…..	DAILY ◊	WEEKLY ◊	OCCASIONALLY ◊	NEVER ◊
ENGLISH TEA	AMOUNT…..	DAILY ◊	WEEKLY ◊	OCCASIONALLY ◊	NEVER ◊
ALCOHOL	AMOUNT…..	DAILY ◊	WEEKLY ◊	OCCASIONALLY ◊	NEVER ◊

PLEASE LIST THE FOLLOWING:

AVERAGE HOURS OF SLEEP AMOUNT……… **QUALITY OF SLEEP** POOR ◊ ON / OFF ◊ GOOD ◊ OTHER, PLEASE SPECIFY……………………………..

AVERAGE WORKING HOURS PER WEEK……..

AVERAGE EXCERCISE HOURS PER WEEK…….. **TYPE OF EXCERCISES**………

SELF - ASSESSMENT

PLEASE LIST CHRONOLOGICALLY THE **EVENTS** IN YOUR LIFE THAT HAVE HAD A **MAJOR PSYCHOLOGICAL IMPACT** ON YOU AND GIVE YOUR **AGE** WHEN THEY OCCURRED.

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MY MAJOR POSITIVE AND NEGATIVE **CHARACTERISTICS** ARE **(+)**…………………………………………………………… **(-)**……………………………………………………….

MY REPETITIVE **DREAM** IS/WAS ……..

MY DEEPEST **FEAR** IS ………

MY **HOBBIES INCLUDE** ………

OTHER **RELEVANT INFORMATION** THAT YOU FEEL LIKE CONVEYING AT THIS POINT:

………

………

STRESS MANAGEMENT

PLEASE **UNDERLINE THE MOST FREQUENT TRIGGERS** OF YOUR STRESS:

RELATIONSHIP WITH………………………………………………………./ MONEY / JOBSECURITY / OTHER(S) – PLEASE SPECIFY

………

PLEASE **UNDERLINE THE PHYSICAL SIGNS** OF YOUR STRESS AND **CIRCLE THE MOST FREQUENT** ONE:

TIREDNESS / NECKACHE / HEADACHE / BACKACHE / CHEST PAIN / PALPITATIONS / DIGESTIVE PROBLEMS / FREQUENT URINATION / LOSS OF LIBIDO / PERIOD PROBLEMS / FREQUENT INFECTIONS / SLEEP PROBLEMS / WEIGHT GAIN OR LOSS / EXCESSIVE SWEATING / OTHER(S) – PLEASE SPECIFY

………

PLEASE **UNDERLINE THE PSYCHOLOGICAL SIGNS** OF YOUR STRESS AND **CIRCLE THE MOST FREQUENT** ONE:

MOODINESS / APATHY / DEPRESSION / ANXIETY / FRUSTRATION / INDECISION / BOREDOM / GUILT / POOR CONCENTRATION / AGGRESSIVENESS / CLUMSINESS / OTHER(S) – PLEASE SPECIFY

………

PLEASE **UNDERLINE THE BEHAVIOURAL SIGNS** OF YOUR STRESS AND**CIRCLE THE MOST FREQUENT** ONE:

BEING ACCIDENT – PRONE / ADDICTIONS (ALCOHOL, DRUGS, SMOKING, TEA, COFFEE) / WITHDRAWAL / CONFLICT MAKING / ABSENTEEISM / OTHER(S) – PLEASE SPECIFY

………

PLEASE DRAW **TWO PICTURES** THAT REPRESENT:

1. **MY HEALTH CONDITION**	2. **MY IDEAL HEALTH**

THE NAME AND CONTACT TELEPHONE NUMBER OF **YOUR GP** ……….
THE NAME AND CONTACT TELEPHONE NUMBER OF **YOUR DENTIST** ……..

SESSIONS INVOLVED IN YOUR TREATMENT

THIS IS A GENERAL OVERVIEW WHICH WILL BE ALTERED TO YOUR CONDITIONS AS NECESSARY
THE PRACTITIONERS ENVOLVED IN YOUR HEALTH JOURNEY ARE DETERMEND BY YOUR PERSONAL IDENTIFIED HEALTH PLAN AND THE EXPERTISE THEY ARE ABLE TO OFFER FOR YOU
ASSESSMENT OF PHYSICAL & PSYCHOLOGICAL WELLBEING
BODYWORK
BIORESONANCE TESTING & LABORATORY TESTING
NUTRITIONAL THERAPY WITH ASSESSMENT, ADJUSTMENT & SUPPLEMENTATION
FLOWER ESSENCE THERAPY
HYPNOTHERAPY WITH POSSIBILITY TO COUNSELLING & PSYCHOTHERAPY
HERBAL & HOMEOTHERAPEUTIC THERAPY
MANUAL LYMPH DRAINAGE
COLONIC IRRIGATIONAL THERAPY

CONTRACTIONAL CONDITIONS

I AGREE THAT MY HEALTH INFORMATION GIVEN CAN BE SHARED BETWEEN **PRACTITIONERS INVOLVED IN MY HEALTH PLAN FOR THERAPEUTIC REASONS ONLY.**

I AGREE THAT THE **SETTLEMENT OF ALL ACCOUNTS REMAINS MY RESPONSIBILITY** AND NOT ANY THIRD PARTY. THE FEE OF TREATMENTS IS **PAYABLE AFTER EACH SESSION** TO THE PRACTITIONER PRESENT. A **FULL FEE** WILL BE CHARGED FOR ANY CANCELLED OR BROKEN APPOINTMENT **WITHOUT 24 HOURS NOTICE**.

I CONFIRM THAT I ACCEPT RESPONSIBILITY FOR ALL CHARGES DUE FOR THE BIOMEDIC SERVICE PROVIDED:

SIGNATURE OF CLIENT / PARENT / GUARDIAN ……………………………………………………………………………………….. DATE……………………………

PLEASE NOTE; IN THE INTEREST OF OTHERS; THE NATURAL HEALTH & BEAUTY CLINIC PROVIDES **MOBILE PHONE FREE TREATMENTS.** YOU ARE KINDLY REQUESTED TO SWITCH YOUR PHONE OF AT THE START OF YOUR HEALTH SESSION.

THANK YOU

WELCOME TO YOUR BIOMEDIC HEALTH JOURNEY