Body Resonance

Customer Contact Form

Title : | **First Name**

Middle Name: | **Surname:**

Address:

Post Code: | **D.O.B:**

Email:

Mobile No. :

Female / Male:

ARE YOU CURRENTLY	YES	NO	IF YES, PLEASE GIVE DETAILS
Receiving treatment from a doctor, hospital or clinic?			
Taking any regular/prescribed medication? Please note all Medication if yes. (Please note any surgeries you've had had in this section):			

What's your primary reason for seeking bio resonance?

_____

When did this first begin?

_____

What was the initial cause?

_____

What makes it worse?

_____

What makes it better?

_____

This problem affects you… (Please tick)

- o Physical well-being
- o Mental well-being
- o Standing
- o Sitting
- o Emotional well-being
- o Walking
- o Personal Relationship
- o Sexual life
- o Exercise
- o Social life
- o Sleep
- o Work life
- o Lying down

How are your energy levels?

- o Great
- o OK
- o Fluctuating
- o Poor

Do you have a high point during the day?

- o Yes
- o No

Do you have a low point during the day?

- o Yes
- o No

Do you sleep well?

- o Yes
- o No

Do you drink tea or coffee?

- o Yes
- o No

Do you smoke?

- o Yes
- o No

Signs / Symptoms - General problems, tick 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 Hair loss
- o Unintended weight loss
- o Unintended weight gain
- o Fluid retention
- o Heavy drinking
- o Smoking
- o Sugar craving
- o Sugar causing negative symptoms
- o Travel Sickness
- o Unusual perspiration
- o No perspiration at all
- o Always hungry
- o Always thirsty
- o None of the above
- o Poor appetite
- o Excessive phlegm
- o Tumours
- o Cancer

Immune system, tick if you have ever had any of the following*

- o Rheumatic disease
- o Arthritis
- o Fibromyalgia
- o Chronic fatigue
- o Frequent colds
- o Ulcerative colitis
- o Measles
- o Morbus Crohn
- o Coeliac disease
- o Hay fever
- o Chronic low-grade fever
- o Swollen glands/lymph nodes
- o Multiple sclerosis
- o Chronic fatigue syndrome
- o Scarlet fever
- o Mumps
- o Syphilis
- o Gonorrhoea
- o Herpes
- o HIV/AIDS
- o Chicken pox
- o Shingles
- o None of the above

Digestive system: tick if you have had any of these

- o Constipation
- o Diarrhoea
- o Dark stools
- o Stools with a very strong smell
- 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 Vomiting
- o Heartburn
- o Liver Cirrhosis
- o Stomach or duodenal ulcers
- o Gastritis
- o Lack of stomach acid
- o Laxative use
- o Haemorrhoids
- o Gallbladder disease
- o Acid Regurgitation
- o Pancreatic
- o Gallstones
- o Hepatitis
- o None of the Above

Head: tick all that you suffer from or have suffered from

- o Headaches
- o Migraines
- o Concussion
- o Loss of Hair
- o Dizziness/Vertigo
- o Premature greying of hair
- o None of the above

Mental / emotional / nervous system: tick all that you suffer from or have suffered from

- o Moodiness
- o Irritability
- o Anxiety
- o Poor memory
- o Dyslexia
- o Short temper
- o Fearfulness
- o Phobia
- o Nervousness
- o Poor connection
- o Confusion
- o Depression
- o Outbreaks of rage
- o OCD/ADD/ADHD
- o Drug addiction
- o Alcoholism
- o Bipolar Disorder
- o Seizure
- o Epilepsy
- o None of the above

Mouth

- Dry Mouth/Throat
- Bleeding Gums
- Abscesses
- Mouth Ulcers
- Root canal treatment
- Crowns
- Joint pain
- Grinding teeth
- Inflammation
- Cold Sores
- False teeth
- None of the above

Nose

- Poor sense of smell
- Congested nose
- Polyps
- Nose bleeds
- Reoccurring sinus infection
- Cold Sores
- None of the above

Ears

- Poor hearing/deafness
- Tinnitus
- Frequent ear infection
- None of the above

Eyes and vision

- Poor vision
- Dry/itchy eyes
- Wind or light sensitivity
- None of the above

Skin

- Eczema
- Acne/ Oily Skin
- Rash
- Abscesses
- Dry / Itchy skin
- Warts

Respiratory system

- Shortness of breath
- Asthma
- Whooping cough
- Coughing blood
- Pneumonia
- Lung abscesses

Urinary Systems

- UTI's
- Kidney stones
- Urinary reflux
- Bladder weakness
- Blood in urine
- Difficulty or pain urinating
- None of the above

Chest and circulatory system

- Fast pulse
- Slow pulse
- Palpitations
- Fainting or dizziness
- Stroke
- Cold hands or feet
- Anaemia
- Bruise easily
- Burning hands or feet
- Hot flushes
- None of the above

Hormones

- Diabetes
- High blood pressure
- Enlarged thyroid
- Hypothyroidism
- Low blood pressure
- None of the above

Muscles, joints and bones

- Injuries to joints or bones
- Injuries to muscles
- Injuries to ligaments or sinews
- Pain in joints or bones
- Pains in muscles
- Pains in ligaments or sinews
- Pains in spine or skull
- Limited range of motion
- Injuries to spine or skull
- Muscle cramps
- Sciatica, weak legs
- RSI/OOS
- None of the above

The following things can affect one's health, even long after they are over, list which apply- Please circle which apply in the past or now

1. **Any Pregnancy or birth complications? Yes / No**
2. **Unusual course of children's diseases and complications from vaccinations? Yes / No**

Your close family's medical history: Please indicate if any of your family members have or had any of the following conditions: Please circle which apply

1. **Allergies? Yes / No / I don't know**
2. **Heart Disease? Yes / No**
3. **Arthritis? Yes / No / I don't know**
4. **Diabetes? Yes / No / I don't know**
5. **Parasites? Yes / No / I don't know**
6. **Tuberculosis? Yes / No / I don't know**
7. **Hepatitis? Yes / No / I don't know**
8. **Cancer? Yes / No / I don't know**
9. **Epilepsy? Yes / No / I don't know**
10. **Seizures? Yes / No / I don't know**

Anything additional you may want to tell us?

Signing this form indicates that you are voluntarily and with full knowledge willing to undergo a procedure referred to as Bio Resonance Therapy (BRT). This is a form of modern bioenergetic science. Treatment is based on bio-physics (the physics of life processes), a field of study in German and British universities that has not yet been widely applied in medicine. The human body is seen as a sea of energy. This energy is made up of electromagnetic fields consisting of physical oscillations (waveforms). These oscillations control body processes and different cells send and receive oscillations at specific frequencies (wavelengths). Neurophysiology is one area where this is recognised and many hospitals use EEG instruments, which measure "brain waves" for diagnosis. BRT is therapy with oscillations received by the BICOM instrument either from the body or from substances, such as viruses or allergens. The BICOM instrument picks up signals from the body though electrodes and returns them in a modified form. Pathological oscillations can be 'inverted' through a mirror circuit to reduce or even eliminate their harmful effect. The aim of BRT is to re-establish the body's ability to regulate itself. Allergy treatment requires abstention from some foods for a few weeks. Possible reactions are tiredness and headaches but these symptoms usually subside after a short time. As the procedure involves only the measurement of changes in the energy flow of the body with a sensitive meter, it is completely safe. The only sensation normally felt is the pressure of the electronic probe against the surface of the skin. The use of a printout recording the results makes this procedure extremely fast. At no time will the technician state or imply a

client should discontinue taking any medication as prescribed by his or her physician. At no time will there be any implied or stated indication to any client to discontinue care under the direction of another physician. This procedure is not intended, implied, or stated to take the place of any conventional medical test or diagnostic procedure. At no time can this office guarantee to resolve a current health concern, however, it has been found that client compliance to the complete recommended therapy usually results in greater and more consistent changes towards better health. This office reserves the right to dismiss any client at any time due to poor compliance with the practitioner's recommended program. I have fully read and understand the above information, the elements of my informed consent, my rights and responsibilities, and hereby give consent to the Bio Resonance Therapy procedure. By using this form, you agree that will store the questionnaire results for our meeting with you. You can request its deletion at any time.

Informed Consent*

- I agree – please tick

Contacting you

- I agree – please tick

To all of our clients, with the new regulations with regards to your personal data and the protection we use for it. We are sharing with you that your data is protected within secured premises and all client notes are locked away. Your information is stored with us for a minimum of 8 years. It is imperative that we have this information to perform safe treatments and have contact with you in the case of an emergency. Our consultation forms have been strengthened and consent is vital and so we will need all clients to sign new consent forms. Consent forms must be clear and distinguishable in clear language. TBSCCs overall appointed data officer will be business owner Denise Akbani. We have to actively seek your permission for the data when updating medical history and contact information and so we will be requiring consent for this.

If you have any questions or queries in regards to this please do not hesitate to ask at reception or to the therapist treating you today.

Date_____

Clients Signature _____

Therapists signature to confirm they have checked and discussed all medical history

_____