New Patient Health Evaluation Questionnaire

Please take the time to carefully complete this questionnaire as fully as possible and either complete it electronically or **bring the completed form with you to your first appointment**. In order to stand the best chance of treating your condition and helping you regain your health, it is important for me to get the whole picture of your health, rather than just look at the obvious symptoms. It will also save time during our consultation. Please answer all questions as best you can, and don't worry if there's anything you are not sure about or you can't remember.

Today's Date:	Name:	Age:	DOB:	Gender:
Address:				
Mobile:	Landline:	Email:		
Relationship Status:		Occupation:		
Any children? (include their ages):		Height:	Current Weight:	Happiest Weight:

Provide details of any medical or allied health professionals you see on a regular basis:

Name & Profession (e.g. GP, Chiropractor etc)	Reason for visiting

How did you find out about me? Please let me know the name of the person who referred you so I can thank them:

Reason(s) for Consultation (please rank in order) :

1.

2.

3.

4.

What symptoms or problems are you currently experiencing?	When did the symptoms begin?	Was there a trauma at this time?

When was the last time that you felt really well?
On a scale of 1-10 (10 being full of vitality and 0 being no vitality) where are you now?
Hobbies:
Overseas travel in last 10 years:
Pets:
Do you have a heart pacemaker?
Do you have a hearing aid?
Any metal implants?
Have you had a transplant?

Childhood History: from birth to 18 years did you suffer from any of the following illnesses? ADD, ADHD, allergies, asthma, bronchitis, chickenpox, colic, croup, eczema, measles, mumps, newborn jaundice, rubella, scarlet fever, tonsillitis, whooping cough. Please insert the condition as appropriate. Severity out of 10 where
1 = mild and 10 = very severe

Health Condition	**Age at onset**	**Age it resolved**	**Treatment received**	**Severity**

Immunisations: Have you had the usual childhood vaccinations?
Are you aware of any side effects or adverse reactions to any immunisations you have received?

Family history of allergies or major disease	
Mother	
Grandmother	
Grandfather	
Father	
Grandmother	
Grandfather	
Siblings	

Your medical History	
Previous and current diseases/conditions	
Previous viruses	

	Answer yes (Y) or no (N). If Yes, please provide details
Allergies and intolerances	
Do you suffer from any allergies, sensitivities or intolerances?	
Emotional/psychological background	
Have you experienced any particularly stressful events within the last 10 years e.g. bereavement of a loved one, divorce, redundancy?	
Do you have concentration or learning difficulties?	
Exercise	
Do you exercise regularly? If yes, please give details of types of exercise, how many times per week you exercise and for how long	

Sleep	
Do you have any sleep disturbance?	
What time do you usually go to sleep?	
Do you have a clock radio next to your bed?	
Do you have electrical devices in the bedroom e.g. TV etc?	
Do you charge a mobile phone or iPad/tablet close to your bed? Do you use it as an alarm?	
Do you sleep near a fuse box?	
How many hours of sleep do you usually get?	
Do you use an electric blanket?	
Do you have Wi-Fi on at night?	

Current medications			
Name	Dosage	For what condition	Since when

Current natural health products			
Name	Dosage	For what condition	Since when

Symptoms that may be attributable to allergies

Circle (or place and X if you are completing online) the extent to which you experience the following symptoms**, leaving blank any that you do not experience**.
Scale: 1 means you seldom experience it and 5 means it is troublesome to you most of the time.

Head

1 2 3 4 5 Headaches
1 2 3 4 5 Migraines
1 2 3 4 5 Sickness
1 2 3 4 5 Pressure
1 2 3 4 5 Throbbing
1 2 3 4 5 Stiff neck
1 2 3 4 5 Stabbing

Ears

1 2 3 4 5 Ringing in ears
1 2 3 4 5 Hearing loss
1 2 3 4 5 Recurrent ear infections
1 2 3 4 5 Earache
1 2 3 4 5 Itching/redness of the outer ear

Nose, throat and mouth

1 2 3 4 5 Metallic taste in mouth
1 2 3 4 5 Mouth ulcers
1 2 3 4 5 Frequent sore throats
1 2 3 4 5 Post-nasal drip
1 2 3 4 5 Stuffy nose
1 2 3 4 5 Sinusitis
1 2 3 4 5 Sneezing
1 2 3 4 5 Swelling of mouth, lips or eyes

Eyes

1 2 3 4 5 Redness, itching
1 2 3 4 5 Blurred vision
1 2 3 4 5 Sandy/gritty feeling
1 2 3 4 5 Seeing spots or lights
1 2 3 4 5 Dark rings under eyes
1 2 3 4 5 Watering eyes
1 2 3 4 5 Dry eyes

Lungs

1 2 3 4 5 Tightness in chest
1 2 3 4 5 Wheezing
1 2 3 4 5 Coughing
1 2 3 4 5 Poor respiratory function
1 2 3 4 5 Hyperventilation

Gastro-intestinal

1 2 3 4 5 Nausea
1 2 3 4 5 Diarrhoea
1 2 3 4 5 Constipation
1 2 3 4 5 Abdominal bloating
1 2 3 4 5 Flatulence
1 2 3 4 5 Burping
1 2 3 4 5 Abdominal distress
1 2 3 4 5 Gastric reflux

Nervous system

1	2	3	4	5	Difficulty thinking clearly
1	2	3	4	5	Memory loss
1	2	3	4	5	Insomnia
1	2	3	4	5	Difficulty waking up
1	2	3	4	5	Cranky on waking

Skin

1	2	3	4	5	Eczema
1	2	3	4	5	Hives (urticaria)
1	2	3	4	5	Rash
1	2	3	4	5	Itching, dryness
1	2	3	4	5	Blotches
1	2	3	4	5	Chilblains
1	2	3	4	5	Excessive perspiration unrelated to exercise

Cardiovascular

1	2	3	4	5	Rapid or irregular pulse
1	2	3	4	5	Chest pain/tight chest
1	2	3	4	5	Palpitations, esp. after eating
1	2	3	4	5	Air hunger or sigh frequently
1	2	3	4	5	Pain on exercise (angina)
1	2	3	4	5	Elevated blood pressure
1	2	3	4	5	Excessive perspiration unrelated to exercise

Genito-urinary

1	2	3	4	5	Urine has a strong odour
1	2	3	4	5	Cloudy, bloody or darkened urine
1	2	3	4	5	Frequency of urination
1	2	3	4	5	Urgency of urination
1	2	3	4	5	Genital itch
1	2	3	4	5	Burning urination
1	2	3	4	5	Elevated blood pressure

Depressed mental state

1	2	3	4	5	Melancholy or low mood
1	2	3	4	5	Depression
1	2	3	4	5	Tearfulness
1	2	3	4	5	Feeling withdrawn
1	2	3	4	5	Lack of confidence
1	2	3	4	5	Confusion

Overactive mental state

1	2	3	4	5	Irritability
1	2	3	4	5	Tenseness
1	2	3	4	5	Anxiety
1	2	3	4	5	Panic attacks
1	2	3	4	5	Overactivity
1	2	3	4	5	Restlessness
1	2	3	4	5	Confusion
1	2	3	4	5	Destructiveness
1	2	3	4	5	Uncontrollable rage

Musculoskeletal

1	2	3	4	5	Swollen, painful joints
1	2	3	4	5	Aching muscles
1	2	3	4	5	Muscular spasm
1	2	3	4	5	Cramps
1	2	3	4	5	Overactivity
1	2	3	4	5	Fibromyalgia
1	2	3	4	5	Shaking (especially on waking)
1	2	3	4	5	Restless legs

Other Symptoms

1	2	3	4	5	Being over- or under-weight
1	2	3	4	5	Fluctuating weight
1	2	3	4	5	Sudden tiredness after eating
1	2	3	4	5	Sudden chills after eating
1	2	3	4	5	Vertigo
1	2	3	4	5	Suddenly feeling unwell
1	2	3	4	5	Feeling unwell all over
1	2	3	4	5	Feeling totally drained and exhausted
1	2	3	4	5	Swelling around eyes, hands, abdomen or ankles

Women only section:

Female Hormonal Health **NB if you are menopausal or post menopausal, please skip this section and answer the questions in the next section**	**Answer yes (Y) or no (N). If Yes, please provide details**
Are you pregnant? If yes, how many weeks?	
Are you breast-feeding?	
Are you trying to get pregnant or planning pregnancy?	
If you are using contraception, what type do you use?	
Have you had any miscarriages?	
Do you have monthly periods?	
What was the date of your last period?	
Are your monthly periods regular?	
How many days does your period usually last?	
What do type of sanitary protection do you usually use? E.g. tampons, sanitary towels, diva cup?	
Do you suffer from pre-menstrual symptoms (eg tiredness, irritability, breast tenderness, mood swings, cravings)?	
Do you have any of the following symptoms associated with your period: cramping, bloating, feeling weak, heavy bleeding, back pain, headaches, bright red blood, dark clotty blood?	
Any other menstrual issues?	
Have you had any abnormal pap smears?	
Do you have breast implants?	

If you are menopausal or post-menopausal, please complete this section:	**Answer yes (Y) or no (N). If Yes, please provide details**
Have your periods stopped? If yes, what was the date of your last period?	
Are you taking or have you previously taken HRT?	
Have you had a hysterectomy? If yes, was it partial or full and when was the surgery?	
Do you have symptoms associated with menopause eg hot flushes, fatigue, aching joints, loss of concentration/memory, loss of libido?	

Nutritional Profile

How many cups of coffee do you drink per day? Type (decaffeinated, percolated, instant):	How many cups of tea do you drink per day? Type (herbal, black):
Do you add sugar to your drinks? YES / NO	Do you add salt to your food? YES / NO
Sugar cravings? YES / NO	Urgent hunger? YES / NO
How many ready-meals do you eat per week?	How many tinned/packet foods do you have per week?
How many take-away meals do you eat per week?	How often do you eat out?
Do you need to snack during the day? YES / NO	How many times a week do you eat confectionery or chocolate?
What percentage of your diet is raw foods/salad?	How many portions of vegetables do you have per day?
How many portions of fruit do you have per day?	How many times per week do you eat fried/fatty foods?
How many times per week do you eat red meat?	How many times per week do you eat oily fish?
How many units of alcohol do you drink per week?	What is your usual alcoholic drink?
Do you use a water filter or bottled water instead of tap water? YES / NO	How many carbonated soft drinks, e.g. coke, do you drink per day?
Is your appetite good/average/poor?	Do you frequently eat under stressful conditions or on the move? YES / NO

Do you have any specific dietary needs? i.e. vegetarian/vegan/gluten free

Are there any foods that you particularly crave?

Are there any foods that you dislike/avoid?

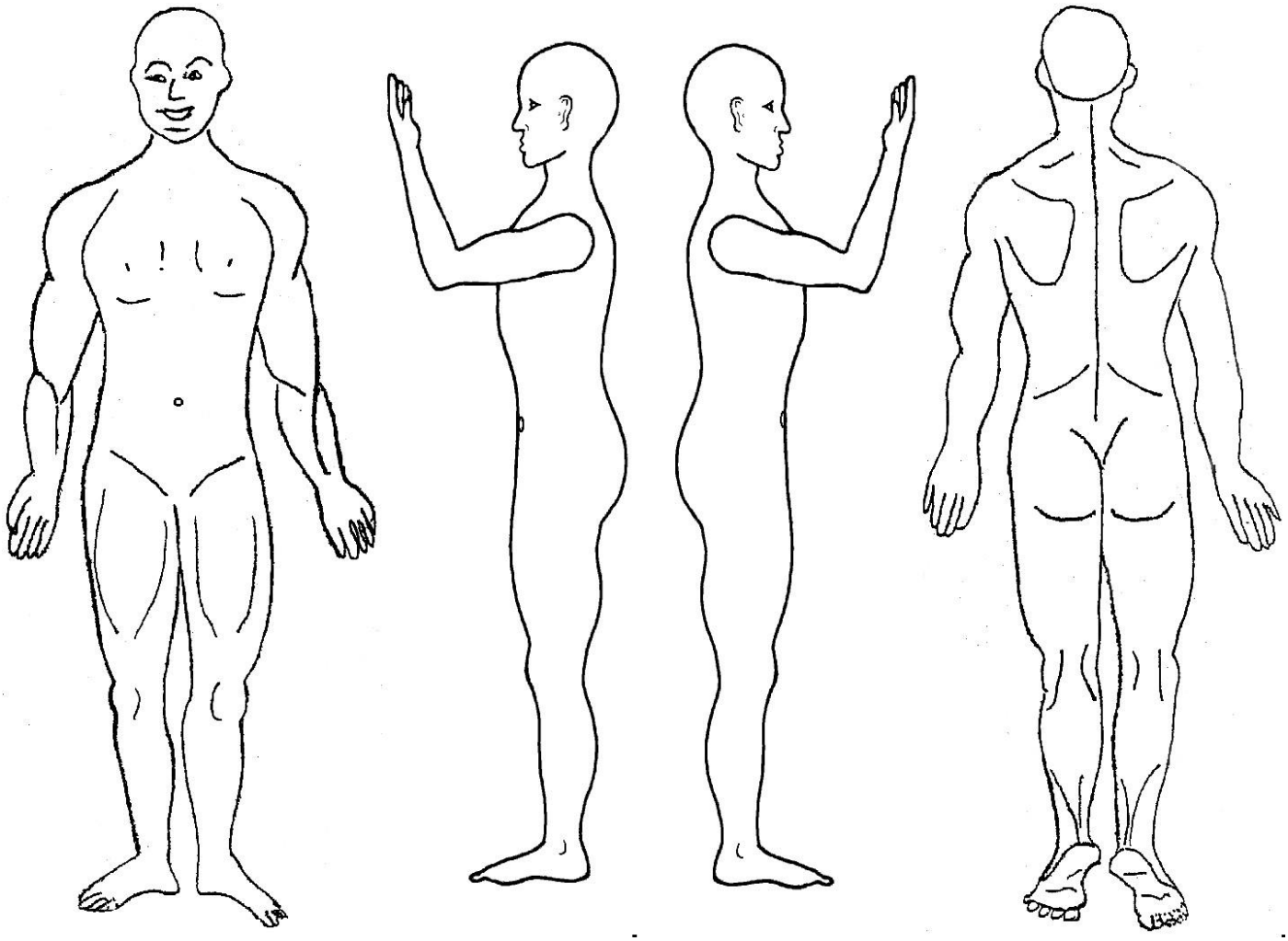
Are there any particular foods or drinks that you would say you are sensitive to?

Please provide details of a typical day's diet:

	Typical mid-week diet:	**Typical weekend diet:**
Breakfast		
Lunch		
Dinner		
Snacks		
Drinks		

Environmental Toxicity Screening	Answer yes (Y) or no (N). If Yes, please provide details
Have you had any x-rays (including dental) in the past three years? If YES, give details. When was your last dental check up?	
Have you had any MRI/CT/ultrasound/ biopsies/endoscopy/mammography/thermal imaging? If YES, give details	
Do you use or have you used aluminium cookware?	
Do you use or have you used spray deodorants or antiperspirants? If so, what kind?	
Do you use or have you used hair colour dyes or bleaches? If so, what kind?	
Do you use antacids?	
How much natural sunlight do you receive daily?	
How many hours per day do you spend daily under fluorescent lighting?	
How many hours per day do you spend watching tv?	
Do you wear a hearing aid? If yes, for how many hours per day?	
Do you use a computer? If yes, for how many hours per day? Do you use a laptop/tablet on your lap?	
Do you hold your mobile phone to your head when using it? If yes, how many hours per day?	
Do you live/work within 30 metres of a transmitter or power lines?	
Do you live/work within 3 miles of a mobile phone tower?	
Do you work near electrical equipment (eg copy machines) for long periods?	
Do you use any recreational drugs including alcohol? If yes, give details including type, amount and frequency & duration	
Do you smoke cigarettes? If yes, what strength and how many per day/week? How many years have you smoked? Do you want to quit?	
Do you smoke e-cigarettes? If yes, what strength and how many per day/week?	
Do you live or have you lived near factories, mines or farming?	
Have you had contact with pesticides, herbicides or crop spraying?	
Have you taken or had injections of cortisone or cytostatics?	
Do you have any piercings or tattoos?	

Scar/Trauma Chart



Directions

All scars

Please draw a *red or blue line* on the drawing where you have scars, even if they are very old. Don't forget c-sections, vaccination scars, surgeries, earring puncture holes, tattoos, facelift scars, injection sites, burn areas, etc.

All trauma areas

Please put a *red or blue X* where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

Internal Metal: Please draw a *circle* on the drawing if you have any type of internal metal objects, such as a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

Date of injury and type of injury

Draw a line from each of the above injury areas and print the type of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988.")

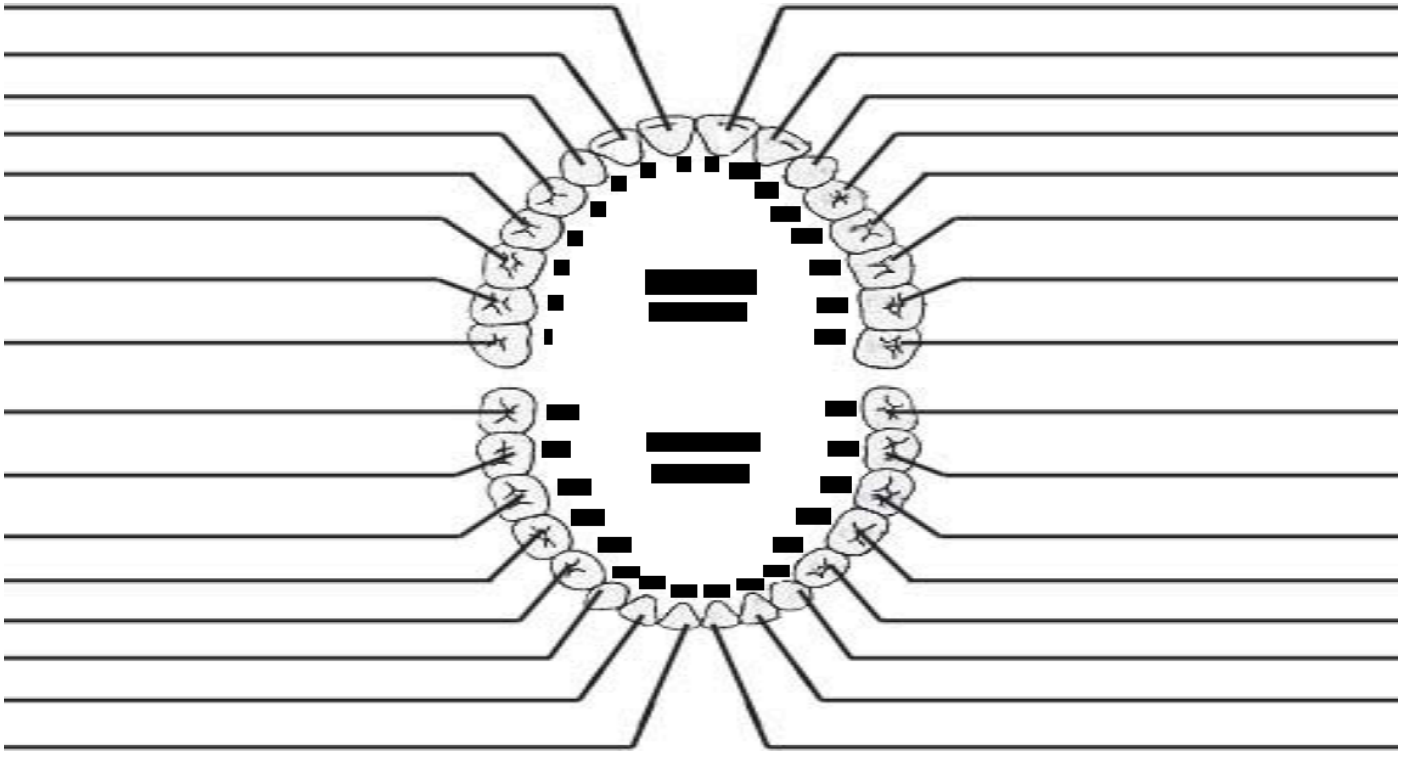
Dental History	Answer yes (Y) or no (N). If yes, please provide details
Do you require dental work at the moment?	
Do you have amalgam fillings?	
Do you have dentures or root fillings?	
Have you had any fillings removed? If so, how many and when?	
Did you follow a detoxification protocol with / after their removal? If so, what did it involve?	

Please fill in the **Dental History Chart** below by writing down what was done to each tooth and the approximate age it was done. *For an extracted tooth, put an X over the tooth*. For example, on the line for left lower second molar, you might write: “Silver filling, age 22.”

Please use the following descriptors:

Silver filling, Composite filling, Gold crown, Root canal, Post (in root canal), Bridge *(circle teeth),* Full denture, Extracted tooth, Partial denture

Right Left



Important note

Twelve hours prior to your appointment, please do not drink any alcohol or strong caffeinated coffee. Please wear loose, comfortable clothing to your appointment.

Many thanks for taking the time to fill in this form. I look forward to working with you.

Jennyblondel.com
MRN. ND. Dip Nut. Dip BM. Dip Hom. Dip RM. CNHC.

Informed Consent for Bioresonance Naturopathic Treatment

I accept the Bioresonance and Naturopathic treatment provided by the below named practitioner.
I understand that:

- Bioresonance diagnosis and treatment, and Naturopathic examination and treatment, are not a substitute for medical examination and diagnosis.
- it is recommended that I see or continue to see a medical doctor (for any physical ailment for which I seek Bioresonance and Naturopathic treatment) if guided to do so by my practitioner.
- the results of Bioresonance testing must always be interpreted while taking into account my medical history, physical attributes, laboratory readings and other results, and this in no way replaces the need for conventional diagnosis. I understand that the Bioresonance test results are particularly important for the resulting energetic therapy with Bioresonance, and that more information can be found on the website: jennyblondel.com
- changes may be made to the treatment along the way to serve a better outcome.
- Bioresonance and Naturopathy have been used safely for many years and can have the effect of normalising physiological functions, and that, on rare occasions, untoward effects may occur.
- despite the best intentions of the practitioner and myself, there may be unresolved symptoms, and that improvement of (all) symptoms is not guaranteed.
- all my records will be kept confidential and will not be released without my consent.
- a specific time is allocated for my appointment and should I arrive late (for whatever reason) I may not receive the full allocated time. I also understand that if I cannot keep my appointment, I am responsible for notifying the Ilkley Healing Centre of the cancellation at least 36 working hours in advance. Otherwise I accept I will be charged the full fee.

I have read, or have had read to me, the above consent, and by signing below I am indicating understanding of the above. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature:	**Date:**
Signature of Parent/Guardian for children under 18 years	
Name of practitioner	
Signature of practitioner	