Natural Systems Alignment
NSA
2/36 Alpha Street, Taringa QLD 4068 (0488 666 316)

CONFIDENTIAL – CLIENT HEALTH HISTORY

NAME: (Mr.; Mrs.; Ms.; Other):_____ D.O.B. _____

ADDRESS: _____

EMAIL: _____ PHONE: _____

The answers to these questions are vital to the efficacy of your treatment.

Please consider the questions carefully and do not leave anything out – however minor or personal you think it might be. What may seem to be irrelevant to you may provide the key to successfully treating you.

DATE: _____ REFERRED BY: _____

MEDICAL HISTORY:

What is your main complaint?

_____

_____

When did your symptoms start? _____

What was happening at that time? Include ANY Life Events, no matter how small:

_____

_____

Have you sought professional help for this in the past? ☐ No ☐ Yes

☐Specialist ☐Naturopath ☐Acupuncturist/Chiropractor/massage therapist ☐Other _____

What was the diagnosis? _____

Have you ever been diagnosed with cancer? ☐ No ☐ Yes – What form? _____ When? _____

Have you received vaccinations? ☐ No ☐ Yes – Please list: _____

_____

Do you have a heart pacemaker? ☐ No ☐ Yes

Do you have a hearing aid? ☐ No ☐ Yes

Do you have any metal implants? ☐ No ☐ Yes

Have you had any surgery? ☐ No ☐ Yes

Have you ever had an accident? ☐ No ☐ Yes – Please list date or age; what happened and outcome – include fractures, bangs on the head or spine and scars: _____

_____

Skeletal problems? ☐ No ☐ Yes _____

Digestive problems? ☐ No ☐ Yes _____

Circulatory problems? ☐ No ☐ Yes _____

Blood pressure? ☐ Balanced ☐ High ☐ Low _____

Fluid Retention? ☐ No ☐ Yes _____

Nervous system problems? (tension, headaches, neck/shoulder pain?) ☐ No ☐ Yes _____

_____

Frequent sinus/coughs/colds? ☐ No ☐ Yes _____

Skin problems? ☐ No ☐ Yes _____

WOMEN ONLY

Are you pregnant? ☐ No ☐ Yes – How many weeks? _____

Menstruation/menopause problems? ☐ No ☐ Yes _____

Endometriosis? ☐ No ☐ Yes – When were you diagnosed? _____

Fibroids? ☐No ☐ Yes – When were you diagnosed? _____

Contraception? ☐ Mirena IUD ("coil") ☐ Implant ☐ The pill ☐ None that is hormonal in origin

HRT? ☐ No ☐ Yes _____

Do you use tampons? ☐ No ☐ Yes – are they organic? ☐ No ☐ Yes

LIFESTYLE

DIET: - Please tick as many boxes as appropriate:

☐ Vegan

☐ Vegetarian (eggs/cheese)

☐ Vegetarian (fish)

☐ Beef (Grass-fed; grain-fed; mainly organic; non-organic

☐ Chicken (mainly organic/non-organic

☐ Pork/bacon

☐ Dairy & Milk

☐ Soy & tofu

☐ Wholemeal grains/bread/flour/rice

☐ Added sugar

☐ Tea/Coffee (circle) How much per day? _____

☐ Tinned food ☐ No ☐ Yes – what sort? _____

Do you have any known food allergies or intolerances? ☐ No ☐ Yes – detail: _____

_____

Do you use alcohol? ☐ No ☐ Yes – how often? _____

How many STANDARD drinks would you have per day? _____

Do you use recreational drugs? (e.g. marijuana) ☐ No ☐ Yes – detail: _____

_____

Do you currently smoke tobacco? ☐ No ☐ Yes – detail: _____

If No, have you ever smoked tobacco? ☐ No ☐ Yes – detail: _____

EXERCISE:

Do you exercise? ☐ Never ☐ Less than once per week ☐ 2-5 times per week ☐ Over 5 times per week

Type of exercise (please list all activities) _____

_____

SLEEP:

How many hours do you sleep per night? _____ Per day (e.g. afternoon naps) _____

☐ Continuous ☐ Broken – How often do you wake on average per night? _____

Reason for waking? _____

Can you get back to sleep? ☐ No ☐ Yes

Do you feel refreshed in the morning? ☐No ☐ Yes

DENTAL:

Do you have any of the following? –

☐ Amalgams (silver fillings) ☐ Root canal surgery ☐ Caps or crowns ☐ Gold or silver teeth

☐ Wisdom teeth extracted ☐ Bridges/Implants ☐ Dentures

OTHER:

Have you ever been bitten by a tick? ☐ No ☐ Yes – when? _____

Do you have any known allergies? ☐ No ☐ Yes – detail: _____

Do your parents have any known allergies? ☐ No ☐ Yes – detail: _____

Do you have tattoos? ☐ No ☐ Yes Do you have piercings? ☐ No ☐ Yes

Does any of your family suffer from alcoholism? _____

Does anyone in your family suffer from the herpes virus? - Cold sores? - Shingles? ☐ No ☐ Yes

Whom? _____

Do you have any hobbies? ☐ No ☐ Yes – detail: _____

Do you have any pets? ☐ No – Do you have contact with other peoples' pets: ☐ No ☐ Yes _____

☐ Yes – detail: _____

PERSONAL CARE:

Do you use deodorant? ☐ No ☐ Yes – What brand? _____

Do you wear makeup? ☐ No ☐ Yes – What brand? _____

Do you use any moisturiser? ☐ No ☐ Yes – What brand? _____

What brand of shampoo do you use? _____

What brand of conditioner do you use? _____

What brand of laundry powder do you use? _____

TRAVEL:

Have you ever travelled overseas? ☐ No ☐ Yes – What countries? _____

_____

HOME:

Have you ever lived or do you live near any of the following?

☐ Busy road ☐Mobile phone tower ☐ High voltage power line ☐Factory ☐ House/apartment (please circle)

Other that you feel may be relevant: _____

Do you live on a farm? ☐ No ☐ Yes

Does your home have a problem with mould? ☐ No ☐ Yes

Where were you living when your problem started? _____

WORKPLACE:

Where do you work now? _____

What job do you do now? _____

Where were you working when the problem started? _____

What job were you doing when the problem started? _____

ELECTROMAGNETIC FIELDS/RADIATION EXPOSURE:

Do you have a mobile phone? ☐ No ☐ Yes

How often do you call on it? ☐ Never ☐ Frequently ☐Moderately ☐ Emergencies only

Do you mainly text? ☐ No ☐ Yes

Do you use a Bluetooth (wireless) headset? ☐ Never ☐ Frequently ☐Moderately ☐ Emergencies only

Where do you normally keep your mobile? ☐ Shirt pocket ☐ Pants pocket ☐ Handbag ☐ Other _____

Have you ever had an x-ray or a scan requiring radioactive materials (e.g.: MRI, radioactive iodine, mammogram etc.) ☐ No ☐ Yes – How many? ☐ 1 ☐ 2-5 ☐ 6 or more

Do you use a microwave oven? ☐ No ☐ Yes

BEDROOM:

Do you have a digital radio alarm clock? ☐ No ☐ Yes

If Yes, how far away from your bed is it? ☐ Less than 1 metre ☐ 2 metres ☐ 3 metres or more

Do you sleep with an electric blanket in winter? ☐ No ☐ Yes ☐ Yes, but I turn it off before I get into bed

Do you have a TV or computer in your room? ☐ No ☐Yes – How far from the bed? ☐Less than 1 metre ☐ 2-3 metres ☐ 5 metres or more

Do you have an in-wall type air conditioner in your bedroom? ☐ No ☐ Yes – How far from the bed? ☐ Less than 1 metre ☐ 2-3 metres ☐ 5 metres or more

PESTICIDE EXPOSURE:

Have you been exposed to pesticides? ☐ No ☐ Yes – Where? _____

Do you use bug spray? ☐ No ☐ Yes

Have your parents been exposed to pesticides? ☐ No ☐ Yes – Where? _____

Do you regularly have your home sprayed for insects? ☐ No ☐ Yes

Do your neighbours spray for insects? ☐ No ☐ Yes

Do you spray weeds? ☐ No ☐ Yes

That concludes the specific questions.

Is there anything else you think we should know about?

THANK YOU!

PLEASE complete the questionnaire as comprehensively as you can.

In order to best treat you, we need to collect some personal and sometimes highly private information.

Please be assured that this form is confidential and the details you give us will not be shared unless your permission is initially sought.

PLEASE now complete the Informed Consent form which is the final page of this document.

Informed Consent

Signing this form indicates that you are voluntarily and knowingly visiting a Bio-Resonance Therapy (BRT) clinic. Your practitioner is not a medical doctor and you will not be given a medical diagnosis. At no time will there be any implied and/or stated indication to discontinue any medication as prescribed by a physician or to discontinue care under the direction of a physician. BRT therapy is complementary to orthodox medicine and is not intended, implied or stated to replace any medical procedure.

You are, of course, entitled to form your own view as to the comparative efficacy of treatments offered by both your BRT therapist and your orthodox medical practitioner and make your own decisions.

You may be tested by a procedure known as Electro-acupuncture according to Dr. Voll (EAV). This is to identify "stressors" that are weakening your body's defences and preventing normal self-regulation of body functions. This testing method is non-invasive (the skin is not punctured), and uses an electronic probe to measure skin conductivity at acupuncture points mainly on the hands and feet but occasionally on the ears. The only sensation that is felt is the pressure of the probe as it is pushed against the skin.

Your BRT therapist uses a BICOM machine to carry out this procedure. In Australia, the BICOM machine is approved for this use under the Therapeutic Goods Act.

The BICOM instrument picks up signals from the body through 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.

Despite its high success rate, success cannot be guaranteed in individual cases. Even in Germany where there are thousands of practitioners, BRT is not recognised by health insurance companies and must be paid for privately. You may withdraw from the treatment program at any time and the therapist also has the right to withdraw due to poor compliance with advice.

I have fully read and understand the above information and authorise treatment.

Signature of Patient (or Parent/Guardian) _____ Date: _____

Name: _____

Address: _____

_____

Name of Witness: _____ Signature: _____