Patient Questionnaire for Biofield Analysis

NAME: ----------

SURNAME: ------ ----------

STREET: ----------

ZIP/CITY: ----------

COUNTRY: ----------

DATE OF BIRTH: ----------

TEL: ----------

EMAIL: ----------

What are your expectations of this Analysis? (Short explanation)

How do you feel ? (Short explanation!)

Previous Illnesses? (Please tick where applicable, possibly a short explanation)

General Illnesses:

Infections:

Asthma Neurological Migriane PMS

Organs :

Heart Kidneys Lungs Stomach Intestines Bladder

Other:

Allergies ?

Medication? (On a sperate page if necessary)

Treatment ? (On a seperate page if necessary)

Vitality

I often feel :

Active & Vital

Sometimes vital, sometimes exhausted

Hyped/overexcited

Tired & exhausted.

Feel mentally tired & sluggish

Appetite:

Mostly a good Appetite

Mostly little Appetite

After Meals:

Feeling of fullness

Flatulence

Mostly tired

I often crave sugars

Sleep:

I can mostly .....

Easily fall asleep

not fall asleep

Easily fall asleep and sleep through

Not fall asleep and not sleep through

I often sweat at night

I need to urinate often at night

Immunity :

I hardly catch a cold

I often catch colds

With almost every 'Flu season I am ill

Feelings:

I can express my feelings easily

I suppress my feelings

Mood swings

Irritability

Nutrition

0= never 1 = selldom 2 = often 3 = regularly 5 = extensively

Vegetables

Fruit

Whole grain products

Meat

Fish

Dairy Products

Coffee

Wheat Products

Alcohol

Cigarettes

Sugars

My Size: ---------- My Weight: ----------

I would like to reduce my weight Yes No

Signature: ---------- Date ----------

Your personal details are stricly confidential and only used for the Analysis

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