Full CGBio Health Test,

This is firstly done remotely. Please send freshly cut hair with completed Medical Form. We then book you in for a 1 Hour Consultation on the Bicom machine

£145.00 inc VAT ☐

CLIENT'S CONFIDENTIAL RECORD

Full Name: _____

Address: _____

Phone: Work: _____ Home: _____ Mob:_____

Email Address: _____

Date of Birth: _____ Age:_____ Marital Status: _____

Occupation_____

GP / family doctor_____

Name and phone no. of your emergency contact person_____

Do you have a heart pacemaker?	□ Yes	□ No
Do you have a hearing aid?	□ Yes	□ No
Any metal implants?	□ Yes	□ No
For women – are you pregnant?	□ Yes	□ No
Have you had a transplant?	□ Yes	□ No

What's your primary reason for seeking bioresonance_____

_____

Is there anything else you would like to add?_____

_____

How are your **energy levels**? Great / OK / Fluctuating / Poor / What's energy?

Do you **sleep** well?	☐ Yes	☐ No	Time of night that you are awake_____
Do you drink **tea or coffee**?	☐ Yes	☐ No	If yes, How many cups/day_____
Do you drink **alcohol**?	☐ Yes	☐ No	If yes, Quantity_____
Do you **smoke**?	☐ Yes	☐ No	If yes, How many/day_____
Do you know your **blood group**?	☐ Yes	☐ No	If yes, please state which _____

To get the best results and to help with the Bioresonance testing procedure please send a small hair sample in a small clean plastic bag. It is not important where the hair is taken from but it must be live hair, not dear hair i.e. from a hairbrush. Hair can still be tested when coloured.

Signs / Symptoms

Please describe your illness / symptoms and say when you started to feel unwell

_____
_____
_____
_____
_____
_____
_____

Please outline any side effects or reactions to any vaccinations, with approximate date/s
DPT_____ HIB _____ MenC _____ Polio _____ MMR _____ BCG _____
Tetanus_____ Small Pox _____ Flu Vaccine _____ Other _____
Travel Vaccines _____
Any Reactions: _____

Please list any prescription or other drugs, currently or previously taken (include any long term prescriptions e.g. HRT, oral contraceptive pill, tranquillisers, please state start/end dates) and any side effects.

_____
_____
_____

Any Supplement _____

Childhood diseases: (include age): Mumps _____ Measles _____ Chicken Pox: _____
German Measles: _____ Whooping Cough: _____ Tonsillitis: _____
Hepatitis: _____ Rheumatic Fever: _____ Scarlet Fever: _____
Glandular Fever: _____
Any bad or long term effects: _____

Have you had any of the following: (include start age): Skin Problems/ Eczema:
Asthma _____ Hay fever _____ Ear Problems _____
Migraine _____

Accidents, with dates _____
_____

Operations, with dates:

_____
_____

Food Intolerances / Other Sensitivities

_____
_____

Height: ____ ft. ____ in. **Weight**: ____ st. ____ lbs.

Medical History: Please circle any of the following areas of health that have caused you problems.

Allergy	Anxiety/ Depression	Anaemia	Abscesses / Boils
Asthma	Blood pressure	Bowel Function	Bloating / Swelling
Back	Catarrh	Chest	Dental
Dizziness	Digestion	Ear / Eye	Fainting
Fears / Phobias	Gall Bladder	Glands	Genital / Thrush
Hay Fever	Heart	Headache	Joints
Kidneys / Urinary	Menstrual	Insomnia	Problems at Birth
Peptic Ulcer	Pregnancy	Rheumatic Pain	Shock/ Bereavement
Piles	Stomach Ulcer	Varicose Veins	Warts/ Verrucas / Moles
Throat Infections	Thyroid	Cancer	
Other:			

Female concerns:

Hormonal imbalance (for women)

Menstruation/menopause problems? ☐ Yes ☐ No

Endometriosis? ☐ Yes ☐ No

Fibroids? ☐ Yes ☐ No

HRT? ☐ Yes ☐ No

Is your cycle regular? ☐ Yes ☐ No

Is your period painful? ☐ Yes ☐ No

Do you take contraceptives? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No Number of pregnancies: ____

Average length of your cycle: _____

Average length of your menstruation: _____

Is there clotting? ☐ Yes ☐ No

Details:_____

_____

Family History

Please give details of your family's past and present health problems (if known). Include all major illnesses, chronic conditions and early death. e.g. asthma, hayfever, eczema, heart problems, cancer, diabetes, arthritis/rheumatism, tuberculosis, stroke, parkinsons, mental illness.

Mother:_____

Father:_____

Maternal G'mother_____

Maternal G'father_____

Paternal G'Mother_____

Paternal G'Father_____

Brothers:_____

Sisters:_____

Cousins:_____

Your Children:_____

Informed Consent

Signing this form indicates that you are voluntarily and with full knowledge willing to undergo a procedure referred to as **BioResonance 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 recognized 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 print out 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 **BioResonance Therapy** procedure.

Patient Name (PRINTED):_____

Patient Signature:_____ **Date:**_____

Signature of Parent/Guardian:_____ **Date:**_____
(optional, if under the age of 16)

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