Confidential Medical and Family History Form
Consent & Privacy Statement

First Name(s): Date of Birth:

Surname: Male / Female (circle)

Address: Status:

Occupation:

Telephone Number:

Postcode: Mobile:

Email: How did you hear about us?

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 Supplements…

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.

*No. of pregnancies: *No. of children: *Blood Group *if known:*

*Alcohol consumption: units per week *Caffeine–what type & how often:

*Cigarettes: per day **or** Ex-Smoker: since (Year)

Continued Overleaf

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, Parkinson's, mental illness.
Mother:
Father:
Maternal G'mother
Maternal G'father
Paternal G'Mother
Paternal G'Father
Brothers:
Sisters:
Cousins:
Your Children:

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

Allergy	Anxiety/ Depression	Anaemia	Abscesses / Boils
Blood pressure	Bowel Function	Bloating / Swelling	Back
Catarrh	Chest	Dental	Dizziness
Digestion	Ear / Eye	Epstein-Barr	Fainting
Fears / Phobias	Gall Bladder	Glands	Genital / Thrush
Lyme Disease	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:			

Full Health Test + 1 Hour Consultation (by phone) £130 inc VAT + pp ☐
Full Health Test + ½ Hour Consultation £98.70 inc VAT + pp ☐
Full Health Test + 1 Hour Consultation + Personalised Weight Management Plan £150 inc VAT + pp ☐

Consent Form:
I confirm that I request a Bioresonance energy balancing session and understand that no promises of cure have been made. It does not replace medical advice.
I am responsible for any withdrawal of medication prescribed to me by my doctor.
I confirm I have read the Privacy statement and agree to my details being kept.

Printed Name: _____

Signed: _____ Date: _____

Optional: I give my permission for …….. (relationship to patient……) to discuss the results on my behalf.
(a child can give their own consent at 16, younger children need a parent or guardian's consent)

Here at Crossgates Bioenergetics Ltd, we take your privacy seriously. We will only use your personal information to administer your account and to provide you with the products and services you requested.
We will not share your information with any other individual or company.
Every so often, we would like to keep you updated with any exciting new products or special offers we feel will interest you.
If you are happy to be contacted for this purpose, please tick below to say how you would like to be contacted: **Email ☐** **Telephone ☐**
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