

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 Destinations: (which countries?)
.....
Covid Vaccines: (which ones? How many?)
.....
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 (First initial test)+ 1 Hour Consultation (by phone) £135.00 inc VAT, excl P&P ☐

Wellness Plan Bespoke 3-Month Plan (plan based on test results) £100.00 inc VAT, excl P&P ☐

Full Health Test (Children)+ 1/2 Hour Consultation £105.90 inc VAT, excl P&P ☐

Follow on analysis £75.00 inc VAT, excl P&P ☐

When washed pendant £55.74 inc VAT, excl P&P ☐

We may use secure AI-assisted software to help prepare and format your wellness reports. Personal information remains confidential and is processed under appropriate data protection safeguards. ☐

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)

**** Julie A Dodgson (Director) is registered with the Alliance of Registered Homeopaths and The Information Commissions Office.****

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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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