MEDISH BIOMAGNETISM THERAPY DATE 1ST SESSION:

Name: _____ Last Name: _____ Date of Birth: / /

Gender: M/F Telephone (s) _____ Email: _____

BSN:_____ Health Insurance:_____ Profession/Work place: _____

Emergency Contact (name and telephone): _____

Attention: please alert me if you have a pacemaker or other electrical devices on your body!

Please circle the ones that apply to you:

Female clients only: Are you pregnant? Yes / No If yes, of how many weeks? Do you still have your periods? Yes / No How often? How many days? Are they light / heavy? Are they painful? Yes / No Additional comments: _____

Last visit to a doctor: _____ Reason:_____

Do you have a previous diagnose? Yes / No

What is it/Date when it was made. Which health provider made it? _____

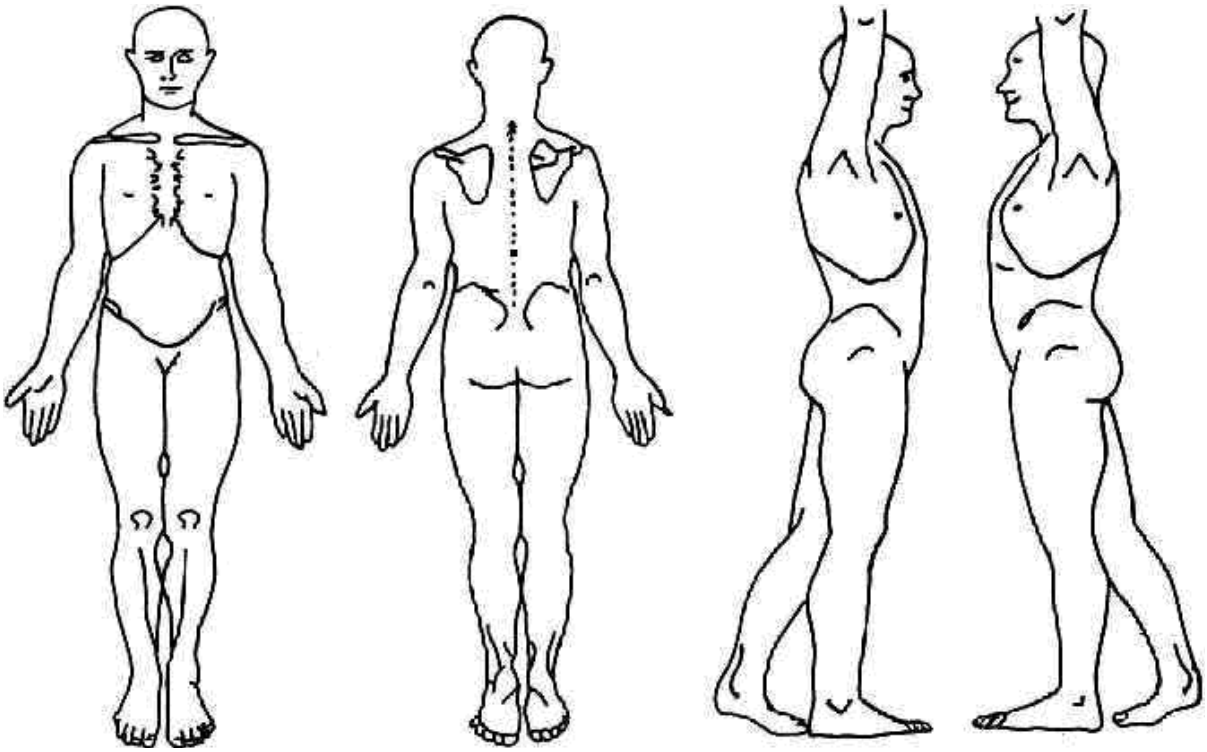
_____

Please say which are your main complains.

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Do you surfer from physical pain(s)? Yes / No. Please mark the place using numbers from 1 - 10 (1 is the most important pain and 10 is the less important):



MEDISH BIOMAGNETISM THERAPY DATE 1ST SESSION:

Please date Mental or Physical Health Problems/Surgery/Chronic Illness

_____

_____

_____

Please circle the ones that apply to you:

Are you taking any medication? Yes /No If yes please state what for:

Are you under psychiatry care? Yes /No If yes, for what reason? _____

_____

What is your doctor's name _____

Are you currently receiving or received any other alternative therapies? Yes /No

If yes state which one (s) and how often?_____

_____

Do you take any vitamins or herbs? Yes /No If yes, please write the name and the Laboratory and how often and for what? _____

_____

_____

How would you rate your health? 1 being the lowest (very poor) and 10 the highest (excellent) _____

How much water do you drink daily? _____ Do you have high/low /normal blood pressure?

What kind of eater are you? (check all that applies)

3 meals daily+ snacks	2 meals daily + snacks	on the run	stress	nervous	eat to live	grazer	for comfort

Other, describe:

_____

When do you eat? Regularly (every x hour)/ moderately hunger/ hunger /starving /when you have to

When do you eat your biggest meal? What is it?

_____

_____

What types of snacks do you eat?_____

Do you have food craving(s)? Yes / No What are they for? _____

Do you have allergies? Yes / No If yes, please state: _____

_____

Do you have food intolorances? Yes / No If yes please state: _____

_____

MEDISH BIOMAGNETISM THERAPY DATE 1ST SESSION:

Please circle the ones that apply to you:

How many bowel movements do you have per day? _____

Do you have:

Diarrhea/diarrhoea	NEVER	SOMETIMES	REGULARY
Gases	NEVER	SOMETIMES	REGULARY
Obstipation	NEVER	SOMETIMES	REGULARY
Feces with mucous	NEVER	SOMETIMES	REGULARY
Yellowish/greenish/black feces	NEVER	SOMETIMES	REGULARY
Blood in the feces (red or dark)	NEVER	SOMETIMES	REGULARY
Undigested food in the feces	NEVER	SOMETIMES	REGULARY

Do you follow a specific diet? If yes please specify _____

_____

Do you drink tea/infusions? Yes / No Do you exercise? Yes / No If yes, how often?

Do you suffer from headaches? Yes / No If yes how often? _____

What are your stress factors? _____

How many hours do you sleep a night? _____ Do you use drugs to sleep? Yes / No

Do you drink caffeinated beverages? _____ If yes, how often & witch ones? _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints/Implants
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____

To receive maximum benefit of a treatment, it is very important to drink plenty of plain water on the 2 days before the therapy (30cl per kg of your weigh on each day) to help flush impurities after the session. It is suggested to rest as needed after a healing session. Most people experience restful sleep, clearer mind, less stress and a feeling of well-being. In some cases, there may be an exacerbation of symptoms on the days after the treatment.

Thank you

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