Quantum BioFeedback Client Questionnaire

*This information will be treated in the strictest confidence*

*Please TYPE in the boxes provided, the boxes will expand as you type so please give as much information as possible, thank you*

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| --- | --- | --- | --- | --- |
| *NAME:* | | *BIRTH DATE:* | | |
| *ADDRESS:* | | *BIRTH TIME:* | | |
|  | | *BIRTH PLACE:* | | |
|  | *POSTCODE:* | *TELEPHONE - HOME:* | | *WORK:* |
| *OCCUPATION: retired teacher* | | *MOBILE:* | | |
|  | | *HEIGHT:* | *WEIGHT:* | |
| *PREVIOUS OCCUPATION:* | |  | | |
|  | | *EMAIL* | | |
| *HOBBIES PAST & PRESENT:* | |  | | |
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*1. Do you suffer from an illness or condition at present? Details & duration please*

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*2. Have you previously suffered from any illness or condition? Details, duration & treatment please*

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*3. Are you currently on any medication? Details and for how long please.*

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*4. Do you experience any of the following symptoms? Please score each between 0 – 10.*

*0 = no symptom, 10 = very bad*

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| *Bloating*  *Bad breath*  *Depression*  *Water Retention*  *Headache*  *Ear Problems*  *Acne*  *Heartburn*  *Impotence*  *Panic Attacks*  *Cold Sores*  *Memory Problems* | *Flatulence*  *Constipation*  *Weight Gain*  *PMS*  *Migraine*  *Excess Mucus*  *Nausea*  *Mood Swings*  *Dark Circles*  *Dizziness*  *Cracked Skin*  *Floaters* | *Indigestion*  *Diarrhoea*  *Weight Loss*  *Lack of Libido*  *Puffy Eyes*  *Muscle Aches*  *Furry Tongue*  *Fatigue*  *Skin Rash*  *Frequent Colds*  *Sensitive Gums* |

*Others:*

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*5. Have you had any eye problems or need for frequent prescription changes? Details please*

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*6. Any ear or hearing problem? Details please*

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*7. How many times a day do you urinate?*

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*8. Have you had any dental work? e.g. numbers of amalgam fillings, wisdom teeth removed, root canals, crowns, bridges.*

*Ceramic or metal?*

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*9. How would you score your stress levels from 0 – 10?*

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*10. Any sleep disruptions? Details please*

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*11. Have you ever taken any pharmaceutical drugs for an extended period of time?*

*If so please specify which, approximately when, and what for.*

*e.g. Antibiotics, Steroids, Cortisone, Heart drugs, diuretics, the Pill, any others*

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*12. Vaccinations with dates:*

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*13. What treatments or investigations have you had / still having? e.g. Doctors' tests, alternative therapies:*

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*14. Do you smoke? How many per day?*

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*15. How many alcoholic drinks do you consume a week on average?*

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*16. Do you have any food or drink cravings? Details please*

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*17. Is there a history of illness in your family? (Grandparents, parents, siblings) Explain where possible please*

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*18. Are you currently taking any vitamin or mineral supplements? Dose & brand please*

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*19. Are you following a specific diet?*

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*Please write down all the foods and drinks consumed over the next two days, starting today. Give as much information as possible including quantities eaten, brand names, and whether the food is fresh or packaged, refined or natural or organic.*

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| --- | --- |
| *Day 1* | *Day 2* |
| Breakfast: | Breakfast: |
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|  |  |
| Lunch: | Lunch: |
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|  |  |
| Dinner: | Dinner: |
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|  |  |
| Snacks: | Snacks: |
|  |  |
|  |  |
|  |  |
| Water in litres: | Water in litres: |
| Drinks: | Drinks: |
|  |  |

*Are these two days representative of your usual eating habits? YES If not, what is a more usual day?*

|  |  |
| --- | --- |
| Breakfast: | |
| Lunch: | |
| Dinner: | |
| Snacks: |  |
| Water in litres: | Drinks: |

*20. Food Reactions: have they been tested? If yes, which foods and what test? Approx date?*

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*21. Was there a physical or emotional period or event in your life that coincided with the start your symptoms?*

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*22. How would you describe your childhood emotionally:*

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*23. Women only: have you ever been pregnant?*

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*24. Travel: Countries visited; stomach upsets, stool tests, medicines abroad?*

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*25. Bowel movements: any irregularities, dates of approx. e.g. constipation as child*

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*26. Are you under any stresses at the moment? What are they:*

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*27. How will having regained your health affect your life? Please list as many positive implications as possible.*

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*If you feel there is more information that has not been included, please feel to add it.*

*All information gained from or given to a client is done so under the strictest confidence.*

*I declare that the information contained within this questionnaire is both accurate and correct to the best of my knowledge.*

*I fully understand that Biofeedback therapy has been designed for stress detection and stress reduction and that the consultant is not diagnosing or curing any illness or disease.*

*I authorize the attending consultant to provide their services to me on my behalf, and release them from any claims arising from my actions or failure to act upon their advice.*

*Signature:*

*Date:*

*Please save your completed questionnaire and email it to me at* [*mary*](mailto:mary.crail@myphone.coop)*@marycrailwellbeing.co.uk. Thank you.*

*“Healing comes from awareness, education, responsibility, faith and the willingness to change” Prof Bill Nelson*