Name:

_____

Address:

_____
_____
_____

Contact Number: **Email:**

_____ _____

Date of Birth:

_____

Gender: Female Male Other Rather not say

Reason for Treatment:

Are you on any Medications, supplements or holistic herbs?

Yes No

If yes, what are they?

Do you have any mercury fillings in your teeth or other extensive dental work?

Yes No

Please note the work done if answer was Yes

Phone: +441642 424265 Mobile: +353879468048
369healthuk@gmail.com
www.369health.love

Do you have regular blood tests?
Yes No
Do you smoke?
Yes No
Do you drink alcohol?
Yes No
Would you consider yourself a healthy eater, lots of fresh vegetables, fruit and water?
Yes No
Do you exercise?
Yes No
Do you have any mental health issues, diagnosed or just noticed by yourself?
Yes No
Please elaborate if answer is Yes

Do you have a support system at home?
Yes No

Any other information

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Disclaimer

Frequency therapy is not a substitute for medical intervention. It is a complimentary therapy and therefore should be undertaken in conjunction with your current medical practitioners. We do not recommend that you stop any of your current medications or cancel any of your medical appointments.

I understand the above information. (circle one)

Yes No

Signature

_____

Print Name

_____

Date

_____

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