CUSTOMER ADMISSION FORM

1 - APPOINTMENT

Agreed date and time for the appointment:

Which service(s) are you interested in? *(Naturopathy, Blood Analysis, Ayurveda, Kinesiology, Dietetics – Tropology, Aromatherapy, Floral Techniques (Bach), Cupping Techniques, Bowen Techniques, Gestalt Method, Phytoceutical Treatments, Phytonutrient Supplements, Herbalism Workshop, Broad-spectrum functional natural treatment, Other)*

What is the main reason you are requesting this appointment?

What are your health concerns?

What are your expectations and what do you want to achieve?

Jurgen Bode

Senior Technician in Chemistry
Pharmacy and Parapharmacy Technician
Naturopath (Col. 4914)
University Expert in Hematological Interpretation and Assessment
Ayurveda Advisor
Kinesiologist

Tel: +34 604 855 995 | +32 486 393 371 **Email: PHUSIS-5331@protonmail.com**

2 – GENERAL INFORMATION

A) FIRST AND LAST NAME:

B) GENDER:

C) ETHNICITY – RACE:

D) BIRTH (date – time – place):

E) ADDRESS – CITY – COUNTRY:

F) PHONE NUMBER *(mobile)*:

G) EMAIL ADDRESS:

H) CHILDREN *(number, boys, girls, ages)*:

I) OCCUPATION *(current job)*:

J) OCCUPATION *(previous job.s)*:

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3 - ESTADO DE SALUD

A) Antecedentes médicos: enfermedades previas, alergias, operaciones, tratamientos médicos y farmacéuticos.

B) Historia de lesiones: fracturas, cortes, quemaduras, tatuajes, piercing, prótesis, etc.

C) ¿Qué partes del cuerpo le duelen y/o le causan molestias?

D) ¿Con qué frecuencia tiene dolores o molestias?

E) ¿Desde cuándo padece las dolencias crónicas por las que nos consulta?

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F) ¿Cómo ha evolucionado su problema de salud desde que empezó?

G) ¿Ha sufrido algún tipo de trauma, depresión, accidente, malos tratos, tristeza?

H) Historia de enfermedades crónicas: diabetes, hipertensión, asma, etc.

I) Historia de infecciones: hepatitis, VIH, tuberculosis, etc.

J) Historia de hospitalización: ingresos previos, duración de la estancia, procedimientos médicos realizados.

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3 - HEALTH STATUS

A) Medical history: previous illnesses, allergies, operations, medical and pharmaceutical treatments.

B) History of injuries: fractures, cuts, burns, tattoos, piercings, prostheses, etc.

C) Which parts of your body hurt and/or cause you discomfort?

D) How often do you experience pain or discomfort?

E) How long have you been suffering from the chronic conditions for which you are consulting us?

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F) How has your health problem evolved since it began?

G) Have you suffered any kind of trauma, depression, accident, abuse, or sadness?

H) History of chronic diseases: diabetes, hypertension, asthma, etc.

I) History of infections: hepatitis, HIV, tuberculosis, etc.

J) History of hospitalization: previous admissions, length of stay, medical procedures performed.

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3 – ADDITIONAL QUESTIONS

A) Do you have any allergies *(food, medication, other)***?**

B) Do you have any addictions *(alcohol, cigarettes, drugs, electronics - TV-computer-mobile phone-.... sex, medication, solvents, soft drinks (Coca-Cola/Fanta,...), carbonated drinks, salt, sugar, caffeine, other)***?**

C) What "allopathic" medication are you taking?

D) What "natural" medications or supplements are you taking?

E) What therapies or treatments are you currently undergoing?

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F) How do you sleep *(bedtime, wake-up time, sleep quality, etc.)***?**

G) What is your diet *(omnivorous, vegetarian, vegan, frugivorous, other)***?**

H) Tell us about your eating habits.

I) Additional Information:

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