FAB Health Clinic

Paulette Agnew
Email: FABhealthclinic@gmail.com Tel/Whats App +447891988602
Skype: Paulette Agnew

Consultation form –

Please complete in English, scan and return by email.

First Name: _____ Surname: _____
Full Address: _____
Phone: _____ Email: _____
Date of Birth: _____ Profession or work: _____

For additional diagnosis and treatment with the Quantum CoRe please give:
Name of your city/town of birth and country. _____

How/through whom - did you find out about us? _____

Which are your main complaints?

1. _____
2. _____
3. _____
4. _____

Which other therapists have you already seen regarding these complaints?
Family doctor: _____
Other doctors / naturopaths / therapists: _____
_____
_____

Which therapy method has given you relief?

_____
_____

Which therapy method was not helpful?

_____
_____

When and why have you received treatment in hospital / in a health clinic?

_____
_____

Did you have the following diseases, or did you get vaccinated?

	I had the disease	I did not have the disease	Don't know	Vaccinated
Measles	___	___	___	___
Mumps	____	____	____	____
Rubella	____	____	____	____
Whopping cough	____	____	____	____
Smallpox	____	____	____	____
Scarlatina	____	____	____	__ __
Hepatitis A / B / C	____	____	____	____
Yellow fever	____	____	____	___ _
Diphtheria	____	____	____	____
Poliomyelitis	____	____	____	____
Chicken pox	____	____	____	____
Typhoid fever	____	____	____	____
CEE	____	____	____	____
Malaria	____	____	____	____
Candida/Mold	____	____	____	____
Epstein Barr	____	____	____	____
Lyme/Borrelia	____	____	____	____
Co-infections	____	____	____	____

Name other Lyme co-infections if you know you have them:

_____

_____

Other vaccinations, when?

_____

_____

Which diseases have occurred (several times) in your family? (Please give disease and family member.)

_____

_____

_____

Which operations have you undergone?

	Year	or	No operation?
Tonsils	_____		__
Sinuses	_____		__
Ears	_____		__
Gall Bladder	_____		__
Appendix	_____		__
Stomach	_____		__
Kidneys	_____		__

Other Operations, for example lower abdomen, hernias, jaw surgery, extraction of wisdom tooth, organ transplantation.

Accidents, fractures:

_____

Severe illnesses / infections:

_____

Addictions (medication, drugs, alcohol, nicotine):

_____

Current medication (e. g. antibiotics, cardiac remedies, blood pressure remedies, cortisone, warfarin, etc.)

_____

Skin diseases, hair loss, skin fungus, fungus of the genitals:

_____

_____

Overseas stays (e.g. India, Africa, South America):

_____

_____

Treatments for fungus, parasites, intestinal reconditioning:

_____

Pregnancies, births, miscarriages, abortion, intake of the "pill", coil

_____

Allergies, intolerances, hay fever? Since when?

_____

Dental procedures (root canal treatment, tooth extraction, amalgam removal, implants, etc.)

_____

Neurological diseases (MS, problems with brain or nervous system, psychiatric diseases) – since when?

_____

_____

Life style	never	rarely	occasionally	regularly	a lot	this is my problem
Smoking	☐	☐	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	☐	☐
Drugs	☐	☐	☐	☐	☐	☐

Sports

Which sports? _____

Autonomic nervous system disorders:

(1 = never, 10 = a lot) 1 2 3 4 5 6 7 8 9 10

Increased temperature _____

Sweating _____

Night sweat _____

Easily excitable _____

Nervousness _____

Easily fatigued _____

Concentration problems _____
Weakness of memory _____
Dizziness _____
Weather sensitivity _____

Cardiovascular System

(1 = never, 10 = a lot) 1 2 3 4 5 6 7 8 9 10

High blood pressure _____
Low blood pressure _____
Poor circulation (where?) _____
Vein inflammations _____
Varicose veins _____
Heart valve defect _____
Myocardial disease _____
Heart attack(s) _____
Arrhythmias _____
Pain in the heart region _____

Hormonal disorders

(1 = never, 10 = a lot) 1 2 3 4 5 6 7 8 9 10

Thyroid _____
Parathyroid _____
Pancreas _____
Ovaries _____
Testicles _____
Pituitary _____
Diabetes _____

Diseases of the respiratory tract / lungs

Bronchitis _____
Pneumonia _____ □
Sinusitis _____
Inflammation of throat / mouth _____

Headaches: (Where [one-sided / on both sides], when, how often?)

_____

Are there things in your life which you would like change but are not able to (private life / work, etc.)?

_____

Sleep disorders (e.g. can't fall asleep, can't maintain sleep, waking up ahead of time)

_____

Do you have painful diseases of the joints / muscles / soft tissues?

_____

Are you pregnant? Yes □ No □

Psychosocial environment

Do you feel stressed by people who are around you? (family members, neighbours, work colleagues, etc.). _____

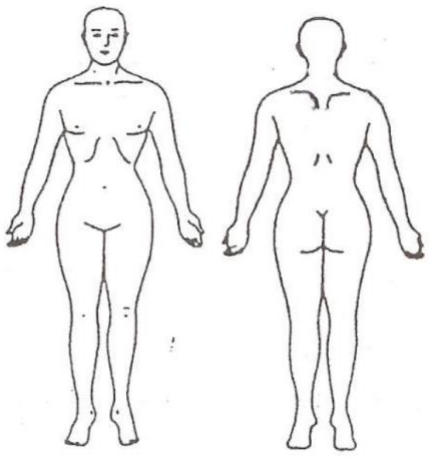
Inner and outer environment	always	often	occasionally	rarely	never
Do you suffer from stress, fears and / or worries?	☐	☐	☐	☐	☐
Do you feel emotionally stressed?	☐	☐	☐	☐	☐
Are you able to relax?	☐	☐	☐	☐	☐
Do you experience emotional crisis?	☐	☐	☐	☐	☐
Do you have problems with your partner?	☐	☐	☐	☐	☐
Are you satisfied with yourself and with the people around you?	☐	☐	☐	☐	☐
Do (did) you work with solvents, cleaning agents, disinfectants, colours, varnish?	☐	☐	☐	☐	☐
Are (were) you exposed to exhaust fumes (cars / traffic / industry)?	☐	☐	☐	☐	☐
Do other people smoke while they are around you?	☐	☐	☐	☐	☐
Do you use a mobile phone or cordless phone?	☐	☐	☐	☐	☐
Are you exposed to electro-smog?	☐	☐	☐	☐	☐

Dietary habits

(1 = never, 10 = a lot)	1	2	3	4	5	6	7	8	9	10
Sugar / sweets / bakery products										
Meat										
Milk / Milk products										
Salad / vegetables										
Fruit										
Whole-grain products										
Lemonade / Coke / Fruit juices										
Coffee										
Tea										

I drink ... litres of water every day: ☐up to 1 ☐ up to 1,5 ☐ up to 2, ☐ up to 2,5 ☐ more than 2,5

Please mark with 'x' areas where you have pain. Please add any relevant information.



Diseases of the digestive organs:

Over acidity _____

Appetite _____

Stool regular □ irregular □

shaped □ pulpy □ smelly □

Constipation _____

Wind _____

Problems with Liver □ Gall bladder □ Hemorrhoids □ Others:

_____

_____

Gynecological / urological diseases

Menstruation disorders _____

Painful menstruation _____

Lengthy menstruation _____

Strong bleedings during menstruation _____

Sterility, unfulfilled child wish _____

Pain in breasts _____

Kidneys _____

Bladder _____

Prostate _____

Inflammations _____

Stones _____

Other information you wish to add.

Date: _____ Signed: _____