

Bioresonance Therapy Questionnaire

Date: _____

Patient Name: _____

General History

Any previous surgeries? List: _____

Any physical or emotional traumas? List: _____

List location(s) of any scars: _____

Any known vaccination reactions? describe: _____

Any known medication reactions? describe: _____

What do you feed your pet? _____

List all medications: _____

List all supplements: _____

Any Pain : location _____

Abnormal bloodwork: _____

Allergies: _____

Please check the box all symptoms or conditions that apply

IMMUNE SYSTEM

- Poor resistance to infection _____
- Auto-immune disorder _____
- Radiation/Chemo exposure _____

URINARY SYSTEM

- Frequent urination _____
- Inappropriate urination _____
- Urinary incontinence _____
- Recurrent bladder infections _____
- Bladder stones _____
- Kidney disease _____
- Reproductive tract problem _____
- Other _____

HEART – LUNGS

- Sneezing _____
- Nasal discharge _____
- Coughing _____
- Bronchitis or asthma _____
- Heart problem _____
- Other _____

DIGESTIVE TRACT

- Vomiting _____
- Diarrhea _____
- Constipation _____
- Excessive gas _____
- Poor appetite _____
- Dental/jaw problems _____
- Oral/Gum disease _____
- Liver problem _____
- Pancreatic disease _____

SKIN

- Itching _____
- Redness _____
- Hair loss _____
- Skin lesions _____
- Recurrent skin infections _____
- Recurrent ear infections _____

MUSCULOSKELTAL

- Pain _____
- Lameness/Stiffness _____
- Back or neck pain _____
- Arthritis _____
- Soft tissue condition _____

NERVOUS SYSTEM

- Seizures _____
- Weakness/Paresis _____
- Other _____

ENDOCRINE SYSTEM

- Thyroid problem _____
- Adrenal gland disease _____
- Diabetes mellitus _____

MISCELLANEOUS

- Tumor(s) _____
- Lack of energy _____
- Mood/behavior disorder _____
- Eye problem _____
- Ear problem _____

Any other concerns or symptoms:
