Health History

REASON FOR VISIT: _____

_____

CURRENT SYMPTOMS: _____

_____

_____

Please check the box if you have experienced any of the following:

- ☐ Heart Disease
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Respiratory Disease
- ☐ Skin Disorder
- ☐ Immune Disorders
- ☐ Allergies / Chemical Sensitivities
- ☐ Endocrine / Hormone Disorder
- ☐ Infection
- ☐ Cancer
- ☐ Surgeries
- ☐ Mental Illness
- ☐ Addictions
- ☐ Scars
- ☐ Amputations
- ☐ Other (Please explain on back)

Please complete back of form

Add additional comments if desired...

OVER →

Health History

Please circle the following answers YES or NO, whichever apply:

1) Do you have a pacemaker or any other battery operated devices in your body? YES / NO
2) Do you have any hardware or implants in your body? YES / NO
3) Are you a highly sensitive person? Do you have strong reactions to food, environment, toxins, people and/or EMF? YES / NO
4) Have you received chemotherapy or radiation in the past 12 months and/or are you currently scheduled for such intervention? YES / NO

If you are under the care of a medical doctor please continue all prescribed medications and treatments. Biomagnetism does not interfere with other therapies.

CLIENT SIGNATURE: _____

DATE: _____

ADDITIONAL COMMENTS: