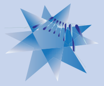
# Consultation Form



## Personal Details

(please write your details clearly)

Title: Mr / Mrs / Ms Full Name:

Address:

Postcode:

Email:

Date of Birth:

Therapy / Profession:

Referred From : Clinic, GP, Therapist, Friend, Family. (If this is the case please mention: Name, Address & Tel No.)

Address: Postcode:

Telephone Details

Home:

Work:

Mobile:

Name:

Telephone:

## Reason for visit

## Section One

1. Do you want to be part of our database? Yes No

Date: Time: Signature:

2. Please describe briefly the nature of the problem or concerns as they relate to the house.

3. For how long, roughly speaking, have you been aware of this?

4. Who in your household are affected? Please specify (myself, daughter, father etc.).

5. Please chose ONE of the people specified in Question 4 who is most obviously affected. The remaining replies will relate to this person. Please specify who this 'chosen' person is.

6. Please describe briefly how this person is affected.

7. For how long, roughly speaking, has this person been affected?

Case Number:

8. Are they receiving, or have they previously received, other treatments for this problem?
Yes No
If yes, please specify which:

9. How would you describe the general health or well being of the chosen person over the last week?
Very good Good Fair
Poor Very Poor

## Section Two - Personal Health for Geopathic Stress

Is it difficult for you to fall asleep? Yes No
Do you suffer from disturbed sleep? Yes No
Do you have frequent nightmares? Yes No
Do you wake up in the morning feeling tired? Yes No
Do you feel tired and exhausted during daytime? Yes No
Do you suffer from chronic fatigue? Yes No
Do you find it difficult to concentrate? Yes No
Do you suffer from headaches in the morning? Yes No
Do you have symptoms without a cause? Yes No
Do your symptoms remain after therapy? Yes No
Do you suffer from autonomic disturbances? Yes No
Do you feel much better at other places? Yes No
Did you symptoms start shortly after a move? Yes No
Do you suffer from bed wetting? Yes No

Have you ever suffered from any of the following problems?

Stress related: Yes No Back pain: Yes No
Heart disease: Yes No Arthritis: Yes No
Palpitations: Yes No Smoker? Yes No
High blood pressure: Yes No
Migraine: Yes No Vertigo: Yes No
Sport injuries or muscle spasm: Yes No
Allergies: Yes No Asthma: Yes No
Respiratory diseases: Yes No Dentals: Yes No
Gynecology: Yes No Infertility: Yes No
Depression: Yes No Anorexia: Yes No
Cancer of any form: Yes No
Anxieties: Yes No Other: Yes No

Please state any other problems here:

Are you currently receiving medical care? ○ Yes ○ No

Are you currently taking medication? ○ Yes ○ No

Have you ever received Alternative Therapy? ○ Yes ○ No If yes, please list type of therapy and date received:

Are you taking any natural supplements? ○ Yes ○ No If yes, please state which one:

Many thanks for your cooperation.
Please be assured that all the information stated above will be treated with the utmost confidentiality and will only be seen by myself.

Jean Marc

## Disclaimer and Declaration

**Disclaimer**

The therapies offered by Jean Marc De Gioanni are not intended to diagnose or treat any disease or physical condition, they do not replace medical care. We suggest you consult your medical practitioner for any medical problems.

**Client Declaration**

I agree to disclose any medical condition, drug or alcohol addiction or any problems that I may have now or at future treatments. I declare that the information that I have given is correct and wish to proceed with treatments.

Client Signature.......................................................

Date.........................................................................

Therapist Signature..................................................

Date.........................................................................