Detailed Questionnaire....

We appreciate if you take time to fill in this questionnaire as precisely and truthfully as possible. It will greatly help us and you to identify hidden factors shaping your health. Together with various other screenings/tests, this information will prove to be very important to generate a synergistic view of client's situation, prognosis and possible wellness protocols which can be tailored to your individual needs. Your personal details and information is strictly confidential, secure and will never be passed to a third party (i.e. your GP) unless specified by you in writing. Only your Holistic Health Practitioner, Kris Zurek, Dip. LBA, Dip. BRT will have access to this form. Questionnaire is for educational purposes only and is not aimed at medical diagnosis or prescription, nor is a substitute for medical care.

… Please remember, we are not treating a disease, but a whole person, thus all the questions presented in this questionnaire are not hasty but have a deeper merit. This is a w/holistic model of life, health and wellness, which stresses the importance of prevention, detoxification as well as restoration of cellular functions. You can only be as healthy as your cells are. And the functioning of the cells depends on multiple factors, which are often ignored or misunderstood. This questionnaire is designed to cover what is often missed by so called conventional medicine.

Please answer these questions to the best of your ability with ***'YES/ NO'*** *or* ***'I DO NOT KNOW'****, or using a* ***'NUMBER'*** *where appropriate.*

Please print this PDF first, fill it in and post it to our address (listed on the bottom of a page). This will speed up our processing of your information/case history and secure more time for you for questions and answers during your personal visit at a clinic.

Thank you for your time and cooperation.

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1. Do you feel often tired (in scale between 1-10) …….
2. Do you feel overstressed (in scale between 1-10) …….
3. Are you overweight ……, underweight ……
4. Do you often feel soreness in your muscles (general) ……, shoulders ……., around the spine & shoulders ……. , legs ……, arms & hands …….
5. Do you have head-aches …….., migraines ……, how often ……..
6. Do you consume products made of pig's meat …….., how often ……
7. Do you adhere to a specific diet (list a type): 1)…… 2) …… For how long …….
8. Do you often crave sugar, sweets, …… or bread ……..
9. Do you crave alcohol ……, do you drink on a weekly basis …….
10. Do you crave coffee ……, how much coffee/tea you drink per day …….
11. Do you consume low-fat products …. , low sugar products (with Aspartame) …..
12. Do you eat Chinese Food with toxic MSG ….. , deep fry …… , crisps ……..,
13. Are you diagnosed with allergies (to what) …… ……
14. Do you have puffiness, "bags" ……., or dark circles under your eyes? …….
15. Do you have white spots on your fingernails? ……..
16. Do you have 'age spots' on your skin? ……..
17. Is your tongue often coated in the mornings ……
18. Do you suffer with bad breath ……..
19. Do you sometimes have metallic taste in your mouth ……
20. Do you have root-canals? How many …….
21. Do you have metal amalgam fillings in your teeth? How many …….
22. Was there any metal amalgam fillings in your teeth in the past? How many……, Were they replaced …….. , Were they pulled out with the teeth ……
23. Do you have gum disease (in the past) ……, (now) ……
24. Do you have any issues with the heart (please name them) ……. ……
25. Is there a history of any disease in your family (please name a disease if applicable): …… …… ……
26. Are your feet and/or hands often cold ……..

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27. Is your core body temperature generally low ……
28. Are you diagnosed with neurological problems ……., please list them: ……..
29. Do you experience memory loss ……,
30. Do you occasionally suffer with dizziness ……., vertigo …….., numbness in fingers ……, pins & needles …….
31. Do you experience ringing in the ears (Tinnitus)……. mild……. severe……..
32. Is any of your senses affected: hearing ……, sight ……, taste ……., smell ……, touch …….
33. Do you experience mental fog ……
34. Did you recently start to lose more hair …… thinning hair ……..
35. Is your ring finger longer than an index finger on your left hand …….
36. (Female) Do you have menstrual cycles, which are painful ……, irregular …….
37. (Female) Do you use the PILL (never) ……(in the past)….., (now) ….. if YES than for how long? ……
38. (Male) Do you experience interrupted …., painful …..or slower urination ……..
39. Do you have any issues with thyroid gland ……
40. Do you use fluoridated toothpaste (in the past) ……, (now) ……
41. What kind of water filtration do you use in your home ……
42. Do you use fluoridated & chlorinated tap water …… drinking …… shower/bath ……
43. Do you drink bottled water ……..
44. How much water do you usually drink ? ……..
45. Are you concerned about wrinkles ….. , sagging skin ….., cellulite …….
46. Do you get sufficient sunshine ……. fresh air …….
47. Do you use sun-screens ….., personal care products with SLS ….., Parabens ….., Propylene Glycol ……, Talc ……, Anti-perspirants …… , Artificial perfumes ……
48. How long do you spend daily talking on mobile phone holding it next to your head ; on average in minutes ……
49. Do you have WIFI in your workplace ……., at your home …….
50. What do you do to protect your health from exposure to EMF & WIFI radiation ……
    ……
51. Do you use chemical based cleaners in your home? ……..

52. Do you use microwave cooker …., do you know they are banned in Russia …….
53. Have you ever done any tests to see if you are nutritionally deficient (please name a tests if applicable):
    ……
    ……
54. Have you ever done any tests to see if you have hormonal imbalances (please name a tests if applicable): …….
    ……
    ……
55. Have you ever done any tests to see if you have heavy metal toxicity (please name a tests if applicable): ……
    ……
    ……
56. Have you ever done any tests to see if you have any pathogens/parasites, bacteria, fungus, mould, bacteria, protozoa, dormant virus (please name a tests if applicable): …….
    ……
    ……
57. Do you experience anal itching? ……. , Itchy skin ……, itchy eyes ……, running nose ……
58. Do you have dandruff? ……, how long ……
59. Do you do any exercise on a weekly basis ……
60. Do you spend most of your day behind the desk indoors ……
61. Do you occasionally experience bloating and/or build-up of gas ……
62. Do you experience constipation or diarrhea …….., on average how many times per month ……, for how many days in a row ……
63. Do you suffer with indigestion ……
64. Do you use laxatives ……., how often …….
65. Do you use any antacids ……., how often ……
66. Do you use pain killers ……., how often ……..
67. Have you been using antibiotics in the last two years ……..
68. Do you suffer with skin condition …., what kind ……., since ……..
69. Have you suffered frequently with infections in your childhood …….. (please name them) ……

70. Do you suffer with depression or anxiety in the past ……., now …….
71. Have you been medicated for depression or anxiety in the past ……..,
    now ……
72. What is your breathing like in a resting state: shallow and very fast (30 to 20 breaths per minute) ……., fast (between 20 and 13) ……. normal (between 12 and 8) ……. or slow (7 and 3) ……..

Please set up a timer and count your breaths in 1 minute. This information is relevant because your health depends on oxygen intake (O2/CO2 ratio)

73. Do you have pet at home ……
74. Do you live on the farm ……..
75. Do you use weed-killer around your house …….
76. If you are a farmer, do you use ship-dip ….. , pesticides ……, insecticides ……
77. Do you live in a countryside with the manure spread in the vicinity ……
78. Have you visited tropical countries in the last two years and experienced a change in your health soon after …….
79. Have you been bitten by the tick in the past ……, when ……..……
80. Have you been bitten by the mosquitos while traveling in tropical countries ……. when ……..
81. Do you have daily contact with chemicals at your workplace ……,
    Can you list them if possible: …….
    ……
    ……
82. Do you have any problems with mould on the walls in your home (in the past) ……, (now) ……
83. Have you been diagnosed /treated for any disease in the past (please name it)
    ……
    ……
    ……
84. Have you had any invasive operations in the past (please name them) :

……
……..

85. Have you recently had any vaccinations? …… (name them): ……
……..
86. Do you know what ingredients are in your vaccine? ….. Do you know if you have intolerance to these ingredients? ……..
87. Do you use any medications? ….. (if YES, than please list them): ……..
……
88. Have you received any dose of radiation in the past 1-4 years; (list the numbers): X-Rays (dose ~1-2 mSv)……., 2D Mammograms (~3-4 mSv)……, 3D Mammograms (~6-8 mSv) ……, CT of lumbar spine (~3-8 mSv) …… , Cerebral Angiographs (~7 mSv) ……., Vascular Angiographs (~20 mSv) ……., Cardiac Angiographs (~70 mSv)……, CT of abdomen/pelvis (~10-70 mSv) ……., Neonatal abdominal CT (~20 mSv)……., CT of Cranium (MSAD) Multiple Scan Average Dose (~50 mSv) ……, Spiral Whole body CT/PET (~30-100 mSv) ……., Barium Enema fluoroscopy scan (~10-85 mSv) ……., Radiation treatments for cancer (~20,000 mSv) …….

6 mSv = equivalent of spending 1 hour in the grounds of Chernobyl in 2010 50 mSv = maximum yearly dose! permitted for the US radiation workers (obviously it should be much less)

89. Have you took ant protective measures against side-effects of radiation (please name them if applicable): ……
……
……..
90. Do you smoke cigarettes? ……. (less than 10) ……., (10-20) ……., (20-30) ……..
91. Did you know that radiation also comes with smoking cigarettes? ……
92. Did you smoke 1.5 pack per day in one year (equivalent of radiation 36mSv) (less) ……. (more) ……. (none) ……
93. Is your house tested for Radon (results): positive (radon in the ground) ……, negative ……., do not know ……..
94. Do you sleep on or have your desk on underground geopathic stress lines
……

95. Do you urinate often at night ……., around which hour ……..
96. Do you suffer with insomnia ……
97. Do you sleep with mouth open ……., do you have sleep-apnea …..
98. Did you suffer any emotional traumas in the past …….. physical injury ……
    what kind: ……
99. Have you received vaccines in your childhood ….., do you know if there were any side effects of these ……
    ……
100. Were there any complications during your birth ……
    ……was it premature? ……..

This space is free for you to write any extra information not listed in this questionnaire but relevant

……
……
……

Statement of declaration and consent

I declare that to the best of my knowledge the answers given to the questions are full and correct. I consent to the natural treatments offered at the holistic centre.

Signature: _____ Date: ¬¬¬_____

Full Name (in capitals) ……

Gender …….. Date of Birth ……..

Address ……
……

Tel: …… Email: ……

Thank you once again for taking the time to complete this important questionnaire. If you have had any problems completing this, or if you have any questions whatsoever, please do not hesitate to contact us.

PLEASE ENSURE THAT YOU KEEP A COPY OF THIS QUESTIONNAIRE, IN CASE YOUR EMAIL OR LETTER DOES NOT REACH US