Confidential Medical and Family History Form
Consent & Privacy Statement

Crossgates health

ALLERGY TEST, NON-FOOD & FOOD INTOLERANCE TEST

First Name(s): Date of Birth:
Surname: Male / Female (circle)
Address: Status:
Occupation:
Telephone Number:
Postcode: Mobile:
Email: How did you hear about us?

Please describe your illness / symptoms and say when you started to feel unwell

Please outline any side effects or reactions to any vaccinations, with approximate date/s
DPT…….. HIB……. MenC……. Polio……. MMR……. BCG…….
Tetanus……. Small Pox……. Flu Vaccine……Other……
Travel Vaccines……
Any Reactions:

Please list any prescription or other drugs, currently or previously taken (include any long term prescriptions e.g. HRT, oral contraceptive pill, tranquillisers, please state start/end dates) and any side effects.

Any Supplements…

Childhood diseases: (include age): Mumps……. Measles……. Chicken Pox: ……
German Measles: ……... Whooping Cough: ……... Tonsillitis: ……. Hepatitis: ……
Rheumatic Fever: ……. Scarlet Fever: ……. Glandular Fever: ……
Any bad or long term effects:

Have you had any of the following: (include start age): Skin Problems/ Eczema:
Asthma: Hay fever: Ear Problems:
Migraine:

Accidents, with dates:

Operations, with dates:

Food Intolerances / Other Sensitivities:			
Height: ft. in.		Weight: st. lbs.	
*No. of pregnancies:	*No. of children:	*Blood Group *if known:*	
*Alcohol consumption:	units per week	(Type: Beer / Wine / Spirits)	
*Cigarettes: per day	**or**	Ex-Smoker: since	(Year)

Family History

Please give details of your family's past and present health problems (if known). Include all major illnesses, chronic conditions and early death. e.g. asthma, hayfever, eczema, heart problems, cancer, diabetes, arthritis/rheumatism, tuberculosis, stroke, Parkinson's, mental illness.
Mother:
Father:
Maternal G'mother
Maternal G'father
Paternal G'Mother
Paternal G'Father
Brothers:
Sisters:
Cousins:
Your Children:

Consent Form:

I confirm that I request a Bioresonance energy balancing session and understand that no promises of cure have been made. It does not replace medical advice.

I am responsible for any withdrawal of medication prescribed to me by my doctor.

I confirm I have read the Privacy statement and agree to my details being kept.

Printed Name: _____

Signed: _____ Date: _____

Optional: I give my permission for …….. (relationship to patient……) to discuss the results on my behalf.

(a child can give their own consent at 16, younger children have to have a parent or guardian's consent)

Here at Crossgates Bioenergetics Ltd, we take your privacy seriously. We will only use your personal information to administer your account and to provide you with the products and services you requested. We will not share your information with any other individual or company.

Every so often, we would like to keep you updated with any exciting new products or special offers we feel will interest you.

If you are happy to be contacted for this purpose, please tick below to say how you would like to be contacted: **Email** ☐ **Telephone** ☐

Crossgates Privacy Statement: The information we collect will be the information you have shared with us overleaf. The information will not be shared with any other individual or company but will be used to help us help you. Information, held electronically or on hard copy, will be stored securely and safeguarded on our computer system. The information will be kept for 7 years. To read the full Crossgates Privacy Statement please go to www.crossgateshealth.co.uk.