

As a new patient, please complete the following information to the best of your ability on **all 3 pages**

npleted: yyyy / mm / dd
ipleted: yyyy / mm / c

MEDICAL INFORMATION & HISTORY

Last Name:				
Name:			Date of Birth:	
				yyyy / mm / dd
Height:	Weight:		Gender:	
Street Address:			City:	
Cell Number:			Alternative Contact N	umber:
E-Mail Address:				
L-mail Address.				
Special Comments / Conce	rns:			
Where did you hear about	us			
Next of Kin Name:	•		Contact Number:	
			Relationship to Patient:	
Method of Payment	Cash	Date		
	EFT	Date		
	Credit Card	Date		

Account Details:

Name of Account: CELLQUICKEN PTY LTD
Bank: First National Bank
Branch: Olympus Plaza

Branch Code: 258-155
Account Number: 62743445555

MEDICAL HISTORY SECTION

Please be thorough and check <u>each system</u> either YES or NO. Provide details of the <u>MOST</u> important medical conditions, complaints or illnesses in every section where YES is indicated in the space provided on page 3.

1	HEART AND CIRCULATION YES NO	2	MENTAL HEALTH	YES	NO	
	Example: chest pain (angina), abnormal heartbeat, high blood pressure (hypertension), heart valve replacement, congenital (born with) heart disease, rheumatic fever, high cholesterol, previous heart surgery (stents, pacemaker).		Example: mood disorders (depression, bipol disorders, schizophrenia, sleeping disorders Alzheimer's disease, autism, attention deficit (ADHD), drug and/or alcohol abuse. Bulimia/	(e.g. narcole -hyperactivit	epsy),	
3	TUMOURS AND GROWTHS YES NO	4	METABOLIC OR ENDOCRINE	YES	NO	
	Example: cancerous skin lesions (basal cell or squamous cell carcinomas), breast disease (cysts/fibromas/infections), breast lumps, non-cancerous or cancerous tumours, malignancies or metastatic cancer (as medically diagnosed).		Example: diabetes I or II (specify which type pituitary gland, osteoporosis, growth deficien disorders, congenital defects, hormonal abnormal example:	cy, metaboli		,
5	GYNAECOLOGICAL & OBSTETRIC YES NO	6	ABDOMINAL	YES	NO	
	Example: cervix conditions (CIN or infections), abnormal/painful/heavy menstrual bleeding, endometriosis, polycystic ovarian syndrome, infections/discharge, ovarian pathology (cysts, absent after hysterectomy), uterus abnormalities		Example: hepatitis, liver cirrhosis, alcoholic failure, pancreatitis, pancreas disorders (insustones, heartburn and reflux, hernias (diaphrulcers, inflammatory bowel diseases (Crohn' colitis).	ılin abnorma agm/umbilic	lities), al/groi	in),
7	BRAIN AND NERVE YES NO	8	BLOOD AND CIRCULATION	YES	NO	
	Example: stroke, brain bleeding (aneurism), epilepsy, motor neuron disease, myasthenia gravis, migraine and headaches, Parkinson's, disease, spinal cord injury, paraplegia (lameness), blackouts (transient ischemic attacks). Speech abnormalities		Example: deep vein thrombosis, anaemia, I ⁻ deficiency), blood clotting diseases, leukaem pulmonary embolus, haemophilia and other I varicose veins, spider veins (telangiectasia).	iia, Ïymphom		,
9	BREATHING AND RESPIRATORY YES NO	10	EYE	YES	NO	
	Example: asthma, chronic obstructive pulmonary disease (emphysema, chronic bronchitis, bronchiectasis), interstitial lung diseases, tuberculosis and other chronic infections, sarcoidosis, pneumonia		Example: cataract (only if currently present), ulcer, uveitis, glaucoma, squint, any abnormation pathy, macular degeneration, cornea to blindness (partial or full), retinal detachment.	ality of eyelic ansplant, ey	ls,	
11	MUSCULOSKELETAL (BACK, BONE YES NO 8 MUSCLE)	12	EAR, NOSE, THROAT (ENT) & DENTISTRY	YES	NO	
	Example: ongoing back pain, scleroderma, dermatomyositis, sarcoidosis, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal column/vertebral conditions, gout, fractures (only at present), physical disability		Example: chronic otitis media (middle ear in externa, hearing problems (<u>specify</u>), hearing tonsillitis, adenoiditis, deafness, nasal surger dental surgery (specify).	aid, cochlea	ar imp	lant,
13	KIDNEY OR URINARY YES NO	14	MALE UROGENITAL CONDITIONS	YES	NO	
	Example: kidney and/or renal failure, kidney stones, recurrent urinary infections, polycystic kidney disease, urinary incontinence, bladder infections, other bladder or kidney problems.		Example: prostate disorders (abnormal PSA urogenital defects, varicocele, tumours, unde phimosis, urinary incontinence, erectile dysfu	escended tes	stes,	
15	IS ONE OF YOUR SHOULDERS LOWER THAN THE OTHER (DROOPING SHOULDER)	16	DO YOU HAVE ABDOMINAL / BELLY FAT?	MODEF EXCES EXTR	SIVE	
17	ANY CONDITION NOT MENTIONED YES NO ABOVE					

If yes, please note those on page 3

	Please describe fully any "YES" answers given above and the duration thereof						
NO	CONDITION		DESCRIPTION	DURATION			
	Please list any al	lorgies you might hav	re (For example: Penicillin)				
	i icaso not any an	lergies you might hav	e (For example, i ememin)				
\vdash							
esta prog suffe any will I conf disc a we it's p usua Adv	I, the undersigned, hereby agree and confirm the following as set out herein. The information and programs written are not intended to serve as substitutes for professional medical advice, diagnosis or treatment. Nor should they be used against your GP's advice or in place of your usual established medical care and/or medications. NEVER disregard professional medical advice, or delay in seeking it, because of information or program(s) received from CellQuicken. Medication should also be used / reduced / increased only as per your doctor's advice. If you think you may be suffering from any medical condition, you should seek immediate medical attention. CellQuicken and their employees are not responsible or liable for any harm or injury to you following any advice, course of treatment, diagnoses or from any information or program that you obtain from us. CellQuicken will keep any information, including personal information relating to yourself, supplied to us in this application, or collected from other sources, confidential. You agree to us processing and disclosing your personal information in the following manner:- we may collect, collate, process, store and disclose your personal information to profile and analyse risk and, if necessary, to forward this information to a contracted third party in order to provide a wellness service to you. You hereby agree that the frequency protocol / program written on your behalf is based on information given by you and that it's purpose is to assist with established treatment procedures and in no way constitutes a medical diagnosis, treatment and/or substitution of your usual medical care. I will also adhere to terms and conditions as described on the website. Advice rendered by Raymond Venter is based on Energy Remedy. Training is through Quantum University- Hawaii.						
Sig	gnature of Patient:		Date Signed: yyyy / mm / dd				