Hi there,

Thank you for your interest in BICOM® Bioresonance REMOTE Therapy.

BICOM-Therapy® uses Biophysics (bio-resonant frequencies that carry healing information), rather than Biochemistry to assist the body’s ability to self-regulate.

With Bioresonance Therapy, we address the whole multi-dimensional being to restore the body and mind, spirit and emotions to an optimal state of balance and harmony.

Biophysics allows us to offer remote Bioresonance sessions using the patient’s blood (preferred), hair or nails.

The outcomes of remote therapy are the same as in-person therapy.

Before you Book an Appointment:

* You MUST request a Blood Sample Kit
* Instructions for Booking a Remote Session and requesting a Blood sample Kit can be found on the website [HERE](https://www.tessgodfrey.com/booking.html)
* Complete this *New Client Intake Form*
  + SAVE this document to your desktop
  + Complete the form online or print, complete & scan
  + Email the form to [tess.godfrey@bigpond.com](mailto:tess.godfrey@bigpond.com)

For your Session:

* You may choose to sit or lie down comfortably at the allocated appointment time, however the benefit of Remote bioresonance therapy is that it is not necessary - you can continue with your day as normal.
* We advise drinking plenty of good quality water on the day of your therapy
* Avoid caffeine on the day

I look forward to connecting with you.

Kind Regards

Tess Godfrey ND

*Naturopath and Energy Healthcare Practitioner*

*ANTA 11298*

**Personal Detail**

Name: Click or tap here to enter text. Date: Click or tap here to enter text.

Mob: Click or tap here to enter text. Email: Click or tap here to enter text.

Address: Click or tap here to enter text.

D.O.B. Click or tap here to enter text. Current Occupation: Click or tap here to enter text.

Who referred you? Click or tap here to enter text.

**Main reason for your appointment:**

Click or tap here to enter text.

**What do you think might be the underlying cause/s of your health concerns?**

Click or tap here to enter text.

**Family History of Allergies or major dis-ease**

Mother: Click or tap here to enter text.

Father: Click or tap here to enter text.

**Describe your Energy Levels during the day**

Click or tap here to enter text.

**Rate your Energy on a scale of 0** (lowest) **– 10** (highest energy)**:** Click or tap here to enter text.

**Describe your STRESS Levels and reasons**

Click or tap here to enter text.

**Rate your stress on a scale of 0** (lowest) **– 10** (highest stress): Click or tap here to enter text.

**Describe you exercise?** Click or tap here to enter text.

**Describe your quality of Sleep:**

Click or tap here to enter text.

**Describe any Digestive concerns:**

Click or tap here to enter text.

**Describe your natural Bowel motions:** How often? Constipated? Diarrhoea? Odour? Any Concerns…

Click or tap here to enter text.

Do you have any **metal implants** in your body? Click or tap here to enter text.

Do you **smoke**? Click or tap here to enter text.

Do you take **Recreational Drugs?** Click or tap here to enter text.

**Known environmental allergies or reactions to medications?** Click or tap here to enter text.

**Current Prescription medications:** (How much? How often?)

Click or tap here to enter text.

**Vitamins/ minerals/ supplements/ herbs:** (How much? How often?)

Click or tap here to enter text.

**Women Only:**

Are you pregnant? Click or tap here to enter text.

Are you breast-feeding? Click or tap here to enter text.

Are you on Hormonal Contraception (Pill, Implant or Injection?): Click or tap here to enter text.

Describe your current Menstrual Cycle (*Mention any symptoms you experience associated with your period:*

Click or tap here to enter text.

**Diet**

Describe your normal Diet:

Click or tap here to enter text.

List all foods that you are specifically excluding and say why *(eg. Peanuts – allergy, Gluten – bloating, Dairy – headaches etc)*

Click or tap here to enter text.

**Dental History**

Do you have silver/amalgam fillings? Click or tap here to enter text.

Have you had root canals? Click or tap here to enter text.

Did you wear dental braces? Click or tap here to enter text.

Any current dental health concerns? Click or tap here to enter text.

**Client Health History**

*Please provide a brief but complete time-line from birth up to today of all major illness, infections, surgery and physical and/or emotional traumas in your life.* (Example: Birth – complications, 11yo - moving home, 17yo Glandular Fever)

Click or tap here to enter text.