

Questionnaire

Please cross out what applies to you:

- | | |
|---|--|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Chronic fatigue |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Irregular bowel movement |
| <input type="checkbox"/> Flatulences | <input type="checkbox"/> Hautprobleme |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Pain in the whole body | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Vaginal fungus | <input type="checkbox"/> Fungus (Skin fungus etc.) |
| <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> painful menstruation |
| <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Difficulty with urinating |

Other: _____

Operations:

- | | |
|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Ovariectomy |
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Cholecystectomy |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Thyroidectomy |
| <input type="checkbox"/> Prostatectomy | |

Other: _____

Do you have pets?

Dog

Cat

Horse

Other: _____

Questions regarding your teeth:

Are your teeth in good condition?

Yes

No

I don't know

When was the last dental panoramic done?

I don't know

My teeth have:

Amalgam fillings

Gold fillings

Porcelain fillings

Plastic fillings

Partial

Old fillings

Root canals

Teeth with big fillings

Bridges

Dentures - bottom

Infections

Dentures - top

Dentures (top and bottom)

When were the amalgam/gold fillings removed? _____

Did you also detox at the same time? _____

