



LEVEL 2 NEW PATIENT QUESTIONNAIRE

ver. 7 Mar 2024

PART ONE : GETTING TO KNOW YOU

Patient's Full Name

Membership

I am a BSI Member Patient

I am not yet a Member Patient

Contact

Profession(s)

Working Status

Working full or part

Not working

On vacation

Retired

Self-employed

Other, please comment

Present Patient Location

Email

Please choose where you want to see the BSI Doctor...

Canggu / Berawa, Doctor Vijas, for all services

Ubud / Sanggingan, Doctor Wisnu, for all services

GWK / Jimbaran, Doctor Igo, for all services

Nationality

When would you like to book an appointment ?

Referred by Whom

Please tell us what services you seek at BSI. You may combine services as needed

BSI Signature Holistic Health Reset & Detox

Brain Fog & Memory Testing & Therapy

Dengue Testing & Therapy

Depression & Anxiety Nutraceutical Therapy

Female Hormones Testing & Therapy

Hypertension (High Blood Pressure) Testing & Therapy

Insomnia (Sleep Disorders) Testing & Therapy

NAD Longevity Therapy, NAD Addictions Therapy

Male Hormones Testing & Therapy

Parasites Testing & Therapy

Super Bugs / Immunities Enhancement

Youth Preservation

Please clarify in detail what you are requesting from BSI

PART TWO : PATIENT VITAL INFORMATION

Are You Able to Care for Yourself, Able to Walk?

YES, I am able to care for myself and walk

NO, I am incapacitated.

Patient Gender

Biological male

Biological female

Different options

Present Age in Years

Date of Birth

Faith, Religion, or Practice

PART THREE : PATIENT REQUEST FOR SERVICES

Please Fully Describe the Illness or Concerns

Present Weight

Present Height

Blood Type (if known)

Blood Thalassemia

No, I do not have Thalassemia

Yes, I have Thalassemia

Hemophilia

No, I do not have Hemophilia

Yes, I have Hemophilia

Describe Your Exercise Habits

Type 0: Not much. Sedentary

Type 1: Occasional short walking, relaxation

Type 2: Yoga, Pilates, stretching, light to moderate swimming etc.

Occasionally raise heart rate high

Type 3: Occasional or frequent running, jumping, trampoline, jogging
(lymphatic stimulation and impact exercise)

Type 4: Weight lifting, muscle building, (endurance training)

Type 5: Super Athletic, trains or works out nearly daily.

Stress Level

- 1 (No or very little stress, easy going, content)
- 2 (Normal stresses of managing a home or local environs, but happy)
- 3 (Normal stresses of challenging work or relationship, could use more rest)
- 4 (Moderate work stresses, challenging emotions, a little cranky but coping)
- 5 (Moderate or higher stresses from disease and / or home life / work life, need time off but can't)
- 6 (Very stressed and emotional, need distance, occasional snapping / yelling at others)
- 7 (Mild anger or sadness much of the time. Work hard to avoid conflict with others, may be taking related medications)
- 8 (Outraged most of the time, depressed, nothing makes sense, over-saturated with surroundings and society, yelling or striking at others)
- 9 (No hope, no patience, beyond ability to be calm or relaxed, unable to sleep)
- 10 (Totally unable to function in the world, restrained from public contact, fully anti-social)

Time I normally go to bed

Time I normally awaken

Nap

- I do not take naps
- I nap (how many times per week)
- I usually nap for how many minutes when I nap

Normal Sleep Habits

- | | |
|---|---|
| I am told I snore at night | Poor sleep gives me headaches |
| I recover from jet lag with difficulty | Poor sleep makes me irritated |
| I have difficulty falling asleep | Poor sleep makes me lose my appetite |
| I fall into a deep sleep | Poor sleep makes it hard for me to think |
| My sleep hours are enough | Poor sleep makes it hard to concentrate |
| I feel vigorous after sleep | Poor sleep makes me lose interest in work or others |
| I am satisfied with my sleep | Poor sleep makes me forget things more easily |
| I have a clear head after sleep | Poor sleep makes me lose desire in all things |
| I wake up while sleeping | Sleepiness interferes with my daily life |
| I wake up easily because of noise | I have difficulty getting out of bed |
| I have difficulty getting back to sleep once | I would like to sleep more after waking up |
| I wake up in middle of the night | I feel refreshed after sleep |
| I toss and turn | |
| I never go back to sleep after awakening during sleep | |

Please comment here

PART FOUR : GENERAL HEALTH QUESTIONS

Usual Diet. Does the Patient Consume these Weekly or Daily?

Wheat products (bread, pasta, noodles etc.)

Please comment here

Sweet bakery items (donuts, cakes, cookies, etc.)

Sweets, candies, chocolate, etc. each day

Need to eat something sweet in or with most or all meals

Common junk foods, chips, cakes, candies, etc

Dairy products (milk, ice cream, cheese, yoghurt, etc.)

Soy products (tofu, tempeh, soy sauce, soy flour, etc.)

Processed, pre-packaged meats (canned meats of any kind, meat mixtures, bacon, lunch meats, sausage, etc.)

Consume boxed, canned, bagged, pre-made foods from super markets (cereals, frozen meals, etc.)

Low-grade fats, (oils of soy, canola, corn, highly processed oils, hydrolyzed shortening, etc.)

Juices, cold-pressed juices, smoothies, shakes, etc.

Powdered foods (spirulina, chlorella, whey, athletic blends, etc.)

Soups, stews, etc.

Coffee, tea, ginseng, chocolate (caffeine containing foods or beverages)

Alcohol, beer, wine, mixed drinks. How often, and what type ?

Clean fresh water. I drink how much each day?

“White foods” (white rice, white noodles, white breads, white sugar, white milk, white salt, etc.)

Raw foods (salads, nuts, sushi, etc.)

Seed oils such as cotton seed, soy, canola, corn, palm, etc.

Clear extra virgin coconut oil (EVCO) or extra virgin olive oil

Wild or semi-wild foods, such avocado, mango, coconut, fresh ocean fish, berries, etc.

Other not listed above. Please explain.

Foods and Beverages Consumed DAILY

Do You Eat in Restaurants / Cafes / Street Vendors, etc?

Almost never

Please comment here

1-3 times per week

3-6 times per week

1 time each day

2 times each day

3 times each day

Nutritional Supplements – Total daily / weekly / monthly

Vitamin A / total daily

Please comment here

Vitamin B Complex or singular B vitamins /
total daily

Vitamin C tablets, pills, powders, etc. /
total daily

Vitamin D / total daily

Vitamin E / total daily

Minerals, combined or singular / total daily

Green powders, spirulina, chlorella, etc. /
total daily

Body building powders / drinks, etc. /
when and how much

Probiotics. Please name type and how often.

Herbal supplements / teas, powders, etc.

BSI Therapure Nutraceuticals consumed
presently or in the past

Injectable supplements / when and totals

Other nutritional items not listed here

None of the above

General Health Questions

Chronic or occasional pain? Please describe

Please comment here

Recent fever

New injuries. Please describe

Old injuries. Please describe

Cold chills or cold sweats

High blood pressure

Low blood pressure

Legs and feet (swelling, stiff joints, etc.)

Arteriosclerosis (blocked arteries)

Never or none of the above

Brain and Head Area

Balding, hair loss, blotchy hair, the patient's hair thinning or falling out prematurely
Pressure headaches
Throbbing headaches
Back-of-the-head headaches
Forehead headaches
Headaches around or behind eyes
Memory lapses
Dizziness or fainting
Diagnosed with a tumor or brain disease
Brain or head injuries at any time in life
Brain surgery
Nervousness, shaking, lack of motor control, etc.
Paralysis anywhere in the body
Lack of feeling anywhere in the body
Over-sensitivity anywhere in the body
Stroke
Scalp problems, dandruff, itching, flaking, etc.
Tumors, growths, moles, warts, etc. on the scalp or head
Other head surgeries, such as on the ear, nose, neck etc.
Something not listed above
None of the above

Please comment here

Oral and Dental

I have very healthy teeth and gums
I have missing teeth, how many
I have chipped or partial teeth
I have diseased or rotting teeth
I have bleeding gums
I have receding gums
I have false teeth or dentures
All or most original teeth been removed
I have amalgam fillings, how many
I have ceramic fillings, how many
I have dental caps or crowns on original teeth
I have new style, more recent root canals

Please comment here

I have old style root canals
I wear or have worn braces
I have dentures or bridges
I have ulcers or growths in my mouth or
my tongue
I have or have had oral herpes
I have lost my sense of taste or smell
I use commercial mouth wash
I am told I have bad breath most of the time
I have excessive amounts of mucous or saliva

Thyroid Disorders / Swelling

Taking thyroid medication? **Please comment here**
Undergone thyroid surgery or removal?
Thyroid area inflamed or in pain?
Exposed to nuclear radiation that may have
affected the thyroid?
Never or not sure

Sinus, Ears, Throat

Recent or previous ear and/or sinus infections **Please comment here**
Any swelling or pain in the throat area
Undergone surgeries in the throat or
on the neck
Recent or previous swollen or painful lymph
glands in the neck or throat area
Strained or dry voice
Lumps or hard nodules anywhere in the mouth,
sinus, gums
Difficulties swallowing
Sticky mucous in the throat area
Something not listed above
Never or note sure on all the above

Eyes

Objects floating in vision ? **Please comment here**
Tunnel vision ?
Poor night vision ?
Wear corrective lenses ?
Eye surgery (alignment, Lasix, repair, etc.) ?
Full or partial blindness ?
Something not listed above ?
None of the above

Digestive System

Difficulty when swallowing ?

Please comment here

Specific digestive issues of the liver, gallbladder, pancreas, stomach, intestines, etc.

Please explain.

Do you have diabetes / hypoglycemia / sugar cravings ?

Sometimes or often constipated ?

Bloating, indigestion, vomiting, excessive gas, etc ?

Occasional or frequent diarrhea ?

Are the feces a strange color, grey, yellow, green, red, black ?

Rectal bleeding, or blood in stool ?

Hemorrhoids (piles)?

Anal itching or irritation ?

Cramping, abdominal pain ?

Any other digestive condition not on the above list ?

Never or none of the above

Respiratory System

Asthma / lung disorders ?

Please comment here

Shortness of breath ?

Chronic cough and/or chest pain ?

Frequent infections ?

Sinus and/or ear infections ? How are they treated ?

Other problems not on this list ?

Never or none of the above

Smoking

Tobacco cigarettes, what brand(s), how often, from when to when please?

Please comment here

Vaping ? What brand(s), how often, from when to when please ?

Cigars, pipes, chewing tobacco, etc ?

Substances other than tobacco ?

Never or none of the above

Kidneys, Adrenal Glands, Bladder, Urinary Tract

Urinary tract surgery? Cause and results ?
Growths or eruptions on or around genitalia ?
Swollen lymph or lumps in around the anus,
perineum, genitals, and surrounding areas ?
Do you experience any pain or discomfort
regarding sex ?
Take diuretics to facilitate urination ?
Urinary tract infections ? Recent or frequent ?
Burning or difficult urination ?
Awakened at night to urinate ? How many
times ?
None of these or other response

Please comment here

Heart and Circulatory System

Arrhythmia (irregular heartbeat) ?
Tachycardia (abnormally fast heart rate) ?
Bradycardia (abnormally slow heart rate) ?
Ever suffered a heart attack ?
Chest pains in or around the heart ?
Heart or related surgeries or therapies ?
Blood disorders ?
Other answer not listed above
Never, none of these

Please comment here

Skin and Body Surfaces

Excessive sweating or body odors ?
Please describe.
Dry or scaly skin ?
Growths, skin infections, skin irregularities of
any kind on the body ? Where, please describe
Excessive bruising, discoloration or spots ?
Please describe.
Varicose veins / Thrombophlebitis ?
Cosmetic skin peels / Glycolic Acid, etc.?
Have you ever injected Botox or similar ?
Fingernail or toenail changes ? Please describe
Skin surgeries / transplants of any kind ?
Result ?
Treated for skin cancer or other growth ?
Where on the body, and when
Problems not listed above
Never or none of these

Please comment here

Male Considerations

Prostate issues – surgery, pain, etc.
Erectile problems ?
Any strange discharge or irritation of the penis ?
Testicle problems – swelling, discoloration, surgery, etc ?
Sexually transmitted diseases (STDs) ? Now or in the past that may have affected your concerns here ?
Taking hormones of any kind that affect reproduction ?
Other condition not on this list.
Please describe here
Never or none of these

Please comment here

Female Considerations

Surgery of the reproductive system ?
Please answer when, reason, and result
Pregnant now ?
Using birth control of any kind ? What type, for how long ?
Taking hormones of any kind that affect reproduction ?
Currently menstruate on a consistent cycle ?
Are menses very heavy or very light, of strange duration ? Please comment.
Menopause ? How long ? Difficulties ?
Sexually transmitted diseases (STDs) ?
Now or in the past
Vaginitis, pain, or vaginal discharge ?
Endometriosis ?
Breast issues (swollen lymph, pain, etc.)
Other condition not listed here
Never or none of these

Please comment here

Projected beginning of cycle

Projected end of cycle

Female Considerations

Purpose of Testing: (when performing full testing, not just specific hormones) Please be sure to schedule hormone testing in sync with menstruation. Please choose your concerns below

General hormonal function: Any time outside of menstruation

Please comment here

PCOS: Anytime outside of menstruation

Fertility / Ovarian function: Test on day 3 (but cannot do urine testing this day)

Menopause / Peri-menopause : Day 3 (but cannot do urine testing this day)

Heavy emotions: Around days 19-22

Light or Heavy menses: Around days 19-22

Specific concerns about Estrogen or

Progesterone: Days 19-22

Missing period: Any time

PART FIVE : PATIENT DISEASE AND CAUSES

Allergies

Animals?

Please comment here

Certain drugs?

Diary products?

Dust?

Mold or mildew?

Nuts or seeds?

Other allergens not listed?

Never or not sure

Autoimmune Disorders

Alopecia areata. Sudden hair loss that starts with one or more circular bald patches that may overlap.

Please comment here

Ankylosing spondylitis. An inflammatory arthritis affecting the spine and large joints.

Celiac disease. An immune reaction to eating gluten, a protein found in wheat, barley and rye.

Lupus. An inflammatory disease caused when the immune system attacks its own tissues.

Multiple sclerosis. A disease in which the immune system eats away at the protective covering of nerves.

Polymyalgia rheumatica. An inflammatory disorder causing muscle pain and stiffness around the shoulders and hips.

Rheumatoid arthritis. A chronic inflammatory disorder affecting many joints, including those in the hands and feet.

Sjögren's syndrome. An immune system disorder characterised by dry eyes and dry mouth.

Temporal arteritis. An inflammation of blood vessels, called arteries, in and around the scalp.

Type 1 diabetes. A chronic condition in which the pancreas produces little or no insulin.

Vasculitis. An inflammation of the blood vessels that causes changes in the blood vessel walls.

Other conditions not listed above.

Never or not sure.

Cancers

Do you now have cancer, or previously had cancer? Please comment

Please comment here

Stage and type of cancer (if any, in detail please)

Results of any previous medical tests.

(Please provide most recent copies when we meet – please do not include here)

Results of biopsy, if any

Intravenous chemotherapy?

Oral chemotherapy?

Hormone therapy?

Radiation therapy?

Holistic or natural therapy for cancers and related diseases?

Other not listed here. Please explain.

Never, or not sure

Hepatitis or Liver Disease

Yellowing of the eyes or skin?

Please comment here

Hepatitis A (HAV) (Hepatitis A is spread primarily through food or water contaminated by stool from an infected person. Hepatitis A is a food-borne or waterborne illnesses.)

Hepatitis B (HBV) (The hepatitis B virus is spread through blood, semen, or other body fluids.)

Hepatitis C (HCV) (The hepatitis C virus is spread through contact with an infected person's blood – because of genital sores or cuts or menstruation. Also through injection drug use, unsafe injection practices, unsafe health care, and the transfusion of unscreened blood and blood products.)

Hepatitis D. (HDV) (Hepatitis D infection only occurs in the presence of hepatitis B virus. HDV-HBV co-infection is considered the most severe form of chronic viral hepatitis.)

Hepatitis E (HEV) (The hepatitis E virus is transmitted mainly through contaminated drinking water. It is usually a self-limiting infection and resolves within 4 to 6 weeks.)

NON-viral Hepatitis. Please describe

Never or none of the above

Herpes

Herpes Simplex 1 (HSV-1) (oral cold sores in or around the mouth or lips. Associated with bipolar disorder, Alzheimer's disease and more)

Please comment here

Herpes Simplex 2 (HSV-2) (genital / anal area breakouts. Associated with (Mollaret's meningitis)

Herpes 3 (HHV-3 or VZV) (chickenpox, shingles, human herpes varicella-zoster)

Herpes 4 (Epstein Barr HHV 4) (associated with mononucleosis, lymphomas, lupus, arthritis, MS, Chronic Fatigue, etc.)

Herpes 5 (cytomegalovirus HHV 5 or CMV) (associated with Infectious mononucleosis ('kissing disease'), retinitis)

Herpes 6 (HHV-6) (associated with Chronic Fatigue Syndrome, cognitive dysfunction, autonomic dysfunction, roseolovirus, lymphotropic virus – infects approximately 70% of humans. Symptoms consistent with hepatitis and encephalitis)

Herpes 7 (HHV-7) (associated with pityriasis rosea. Also associated with drug-induced hypersensitivity syndrome, encephalopathy, hemiconvulsion-hemiplegia-epilepsy syndrome, hepatitis infection, postinfectious myeloradiculoneuropathy, pityriasis rosea, and the reactivation of HHV-4, leading to “mononucleosis-like illness”))

Herpes 8 (HHV-8) (Associated with neoplasms. Diseases caused by HHV-8 infection include Kaposi Sarcoma, Multicentric Castleman Disease (MCD), Primary Effusion Lymphoma (PEL), which occur primarily in patients with HIV infection)

ParvoVirus (B-19) (associated with slapped cheek syndrome, sero negative arthritis, aplastic anemia, sickle cell disease, encephalitis, meningitis, stroke, peripheral neuropathy, and more)

Not sure or other condition not listed above.

Please explain

Never or none of these

Toxic Exposures

Exposed to chemicals or toxins related to machine work, solvents, fuels, industrial cleaners, etc?

Please comment here

Insect or weed killers in the house or around where you are (how often, what brand?)

Insect repellants sprayed or rubbed onto the body (how often, what brand?)

Briefly describe any toxic chemical exposures at any time during the Patient’s life

Party favors in the past three years

Other exposures not listed above.

Please explain

Never or none of the above

Radioactivity Exposures

Radioactive exposures from frequent flying
(how many flights per year?)

Please comment here

Radioactive exposures from CT scans, MRI,
X-rays. How many times? Was 'contrast'
injected into the body during the procedure?

Use of cell phone next to the head (how many
hours per day on average?)

Live within 100 meters of a cellular or radio
broadcast tower? Please explain.

Have lived or worked near a nuclear power
plant or nuclear facility?

Have lived near or visited Chernobyl,
Fukushima, Hanford or other contaminated
area?

Have suffered from unexplained sudden hair
loss or skin mottling, etc?

Any other source of radioactivity not listed
above. Please explain

Never or none of the above

PART SIX : MEDICATIONS PAST AND PRESENT

Common Medications the Patient has Taken during the Past 2 Years or Less

Aspirin / Other pain killers

Please comment here

Ibuprofen (Advil / Motrin)

Panadol / Paracetamol / Tylenol / Benadryl /

Acetaminophen

Sudafed / Claritin / anti-histamine

Diuretics (ease urination)

Coumadin/ Heparin/ blood thinners
(stroke prevention)

Statins for cholesterol, (Lipitor, Crestor, Zocor)

Prozac or similar

Anti-fungal (on skin or orally)

Estrogen / HGH / other hormones

Other not listed above Please describe. Thanks.

None of these

All CURRENT medications, supplements, herbal medications, etc. you are taking

Vaccines or Inoculations – Did you have reactions ? If so, how and where? Did you experience the covid infection afterward ? Have you received these over the years?

COVID 19 – FIRST SHOT – Did you have reactions? Please explain. **Please comment here**

COVID 19 – SECOND SHOT – Did you have reactions? Please explain.

COVID 19 – FIRST BOOSTER SHOT – Did you have reactions? Please explain.

COVID 19 – SECOND BOOSTER SHOT – Did you have reactions? Please explain.

PCR SWAB – How many times have you taken the PCR / Swab ? It's okay if you have taken the PCR test or not, no problem. Fully private information. We need to know so we can give proper diagnosis. Thanks! Did you experience reactions ? If so, did you lose your sense of taste or smell ? Did you get a covid infection afterward ?

Chickenpox (Varicella)

Cholera

Current flu vaccination every flu season

Diphtheria-tetanus-pertussis (DTP) vaccine

Haemophilus influenzae type b (Hib)

Hepatitis A

Hepatitis B

HPV vaccine

Japanese Encephalitis

Malaria

Measles-mumps-rubella (MMR) vaccine

Meningococcalconugate vaccine

Meningitis

Pneumococcal (PCV)

Polio vaccine

Rabies

Rotavirus (RV)

Td or Tdap vaccine (tetanus, diphtheria, and pertussis) booster each 10 years.

Typhoid and paratyphoid fever

Varicella (chickenpox) vaccine

Yellow Fever

Zoster vaccine

Other vaccination not listed above, please explain

Not sure

Antibiotics in the Past 10 Years

Please comment here

Amoxicillin. A penicillin antibiotic prescribed for tonsillitis, bronchitis, pneumonia, gonorrhea, and infections of the ear, nose, throat, skin, or urinary tract, and more.

Amoxicillin / Clavulanate. A combination penicillin antibiotic that fights bacteria in the body.

Azithromycin. Given for respiratory, skin, and ear infections, and sexually transmitted diseases.

Cephalexin. Prescribed for upper respiratory infections, ear infections, skin infections, and urinary tract infections.

Ciprofloxacin (fluoroquinolone). Prescribed for anthrax, plague, stomach disorders and more.

Clindamycin. A wide-spectrum antibiotic that fights bacteria in the body.

Doxycycline. For urinary tract infections, intestinal infections, eye infections, gonorrhea, chlamydia, periodontitis (gum disease), and others.

Levofloxacin (fluoroquinolone). For skin, sinuses, kidneys, bladder, prostate, bronchitis, pneumonia, anthrax.

Metronidazole (Clindamycin hydrochloride). A strong wide spectrum antibiotic that fights bacteria in the body.

Sulfamethoxazole / Trimethoprim. Used to treat or prevent wide spectrum of bacterial infections.

An antibiotic not on this list.

Exposure from foods such as chicken, eggs, fish, meat, etc.

Never have taken antibiotics.

PART SEVEN : MEDICATIONS PAST AND PRESENT

Happiness and Well Being

I am generally happy and content...

Please comment here

My strengths are...

My weaknesses are...

I suffer / have suffered from depression...

I suffer / have suffered from anxiety...

I have taken / take medications for depression or anxiety...

I am easily angered, triggered by...

I practice / have practiced a form of mind centering, such as meditation or quiet time...

Other answer not listed above

Therapies Received in the Past 2 Years or Now Receiving

Acupuncture

Please comment here

Aromatherapy

Chelation therapy

Colonic therapy

Detoxing

Cannabis

Chemotherapy

Herbal medicine

Homeopathy

Naturopathy

Oxygen therapy

Prolo Therapy

Radiation Therapy

Reiki

Vitamin C infusions (dosage, how often, any side effects ?)

Other therapy not on this list

Never or none of the above

Surgeries and Operations

Appendix removed

Please comment here

Tonsils removed

Digestive surgeries

Elective surgeries. Please explain

Emergency surgeries

Eye operations

Heart

Skin operations, including growths or cancers, etc.

Other surgeries not listed above, please explain here

None of the above

Anti-Fungal Medicines

Oral anti-fungal medicines?

Please comment here

Topical anti-fungals?

Not sure or other medicine, please explain

Never or none of the above

Parasites

Treated for digestive parasites? If so when and how. Did the treatment work?

Please comment here

Treated for skin or hair parasites?

Frequent bloating or gas?

Anal bleeding or itching?

Strings or mucous in the stools?

Do you live with dogs or cats?

Other parasite problems not listed here.

Please explain

Never or none of these. Please explain

Anything Else of Relevance

Note :

Please fill this offline form, then Save it

Send this form via email to : **survey@bsi.international**

- or -

Print and bring with you to your first meeting.

(Please note this will add 30 minutes to your first visit).