BSI International
Integrative Natural Health

Yayasan Bali Sehat Indah International & PT Serba Alami Nusantara
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LEVEL II NEW PATIENT QUESTIONNAIRE

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PART ONE : GETTING TO KNOW YOU...

Patient's Full Name ______________________________

Present Patient Location ______________________________

Location in Bali ______________________________

Email Address ______________________________

Complete Phone Number(s) and / or WhatsApp ______________________________

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

Canggu / Berawa, Doctor Vijas, for all services, lower price.

Ubud / Sanggingan and - or Jimbaran / GWK, Doctor Wisnu, for all services, lower price.

GWK / Jimbaran, all available Doctors for all services.

Nationality ______________________________

Appointment ______________________________

Referred by Whom ______________________________

Please tell us what services you seek at BSI...	**Comments:**
BSI Signature Holistic Health Reset & Detox, Testing & Diagnosis With Natural Therapies Youth Preservation, Testing & Diagnosis With Natural Therapies Brain Fog & Memory, Testing & Diagnosis With Natural Therapies Depression & Anxiety, Testing & Diagnosis With Natural Therapies Female Hormones, Testing & Diagnosis With Natural Therapies Hypertension (High Blood Pressure), Testing & Diagnosis With Natural Therapies Insomnia (Sleep Disorders), Testing & Diagnosis With Natural Therapies Male Hormones, Testing & Diagnosis With Natural Therapies Super Bugs, Testing & Diagnosis With Natural Therapies	

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. Please comment

Patient Gender ____

Present Age in Years ____

Date of Birth ____

Faith, Religion, or Practice ____

PART THREE ART THREE : PATIENT REQUEST FOR SERVICES ...

Please Fully Describe the Illness or Concerns

Comments:

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	Comments:
Please choose all that may apply Type 0: Not much. Sedentary Type 1: Occasional short walking, relaxation Type 2: Yoga, Pilates, stretching etc. Occasionally raise heart rate high Type 3: Occasional or frequent running, jumping, trampoline, jogging , horseback (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	Comments:
On a Scale of 1 to 10 (10 being the strongest stress), what is your current stress level?. If possible, please describe 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)	

PART FOUR : GENERAL HEALTH QUESTIONS

Usual Diet. Does the Patient Consume these Weekly or Daily? **These items are not necessarily bad or good, nor is this a judgement.** **We ask your honest answers to help us analyze your current health needs.** Wheat products (bread, pasta, noodles etc ?) Sweet bakery items, 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, cheese, yoghurt, etc ?) (milk, ice cream, cheese, yoghurt, etc.) Soy products (tofu, tempeh, soy sauce, 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 ? 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. How much does the patient drink on average per day ? “White foods” (white rice, white noodles, white breads, white sugar, white milk, white salt, etc ?) Raw foods, such as salads, nuts, sushi, etc ? Common 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.	**Comments:**

Foods and Beverages Consumed DAILY

Comments:

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

If possible, please tell us the names of those you most frequent

- Almost never
- 1-3 times per week
- 3-6 times per week
- 1 time each day
- 2 times each day
- 3 times each day

Comments:

Nutritional Supplements

Please tick all that may apply

Details here reveal imporant information about your health history and needs

- Vitamin A / total daily
- 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.
- Injectable supplements / when and totals
- Other nutritional items not listed here
- None of the above

Comments:

General Health Questions	Comments:
These answers help to analyze current health conditions Chronic or occasion al pain? Please describe Recent fever? 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	Comments:
Have you experienced any of the following? Balding, hair loss, blotchy hair, Is 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	

## Thyroid Disorders / Swelling	**Comments:**
Tick all that apply Taking thyroid medication? 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	

## Oral, Dental, Sinus, Ears, Throat	**Comments :**
Tick all that apply Ear and/or sinus infections ? Diseased or rotting teeth, how many ? Bleeding gums ? Receded gums (stem of tooth exposed) ? Chipped or partial teeth, how many ? Amalgam (metal) fillings, how many ? Have amalgam filling been removed / replaced ? Ceramic (white) fillings, how many ? Dental caps or crowns on original teeth ? Old style root canals, how many ? New style, more recent root canals, how many ? Dentures or bridges, partial or full ? Have all or most original teeth been removed ? Presently wearing braces ? Any swelling or pain in the throat area ? Undergone surgeries on the head or neck ? Swollen or painful lymph glands in the neck or throat ? Strained or dry voice ? Lumps or hard nodules anywhere in the mouth, sinus, gums ? Never or note sure on all the above	

## Eyes	**Comments:**
Please check all boxes that may apply Objects floating in vision ? 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	Comments :
Please check all boxes that may apply	
Difficulty when swallowing ?	
Specific digestive issues of the liver, gallbladder, pancreas, stomach, intestines, etc.	
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	Comments :
Please tick all boxes that may apply	
Asthma / lung disorders ?	
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	Comments :
Please check all that apply	
Tobacco cigarettes, what brand(s), how often, from when to when please?	
Vaping ?	
Cigars, pipes, chewing tobacco, etc ?	
Substances other than tobacco ?	
Never or none of the above	

Kidneys, Adrenal Glands, Bladder, Urinary Tract	Comments :
Please check all that apply 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	

Heart and Circulatory System	Comments:
Please check all boxes that may apply Arrhythmia (irregular heartbeat) ? Tachycardia (abnormally fast heart rate) ? Bardycardia (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.	

Skin and Body Surfaces	Comments:
Please check all boxes that may apply Excessive sweating or body odors ? Dry or scaly skin ? Growths, skin infections, skin irregularities of any kind on the body ? Where, please describe Excessive bruising, discoloration or spots ? 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	

Female Considerations	Comments:
Please check all boxes that may apply	
PATIENT IS MALE, does not apply	
Date of your period this month	
Surgery of the reproductive system ?	
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 ?	
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	
None of the above	

Male Considerations	Comments :
Please choose all that apply	
PATIENT IS FEMALE, does not apply	
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	

PART FIVE : PATIENT DISEASES AND CAUSES ...

Allergies **Do you experience allergic reactions to the following?** **What are the symptoms, and remedies taken?** **Please ONLY tick the boxes that may apply to you** Animals? Certain drugs? Diary products? Dust? Mold or mildew? Nuts or seeds? Other allergens not listed? Never or not sure	**Comments :**

Autoimmune Disorders

Do you curently or in the past suffer from any of these?Please tick all boxes that may apply

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

Comments :

Cancers	Comments :
Please check all boxes that may apply. Add comments as needed Do you now have cancer, or previously had cancer? Please comment 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	Comments :
Please check all boxes that may apply Yellowing of the eyes or skin? 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	

Toxic Exposures	Comments :
Please check all boxes that may apply. Dates and comments are helpful. Exposed to chemicals or toxins related to machine work, solvents, fuels, industrial cleaners, etc? 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	Comments :
Please check all boxes that may apply. Comments are very helpful Radioactive exposures from frequent flying (how many flights per year?) 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	**Comments :**
Add comments as needed	
Aspirin / Other pain killers	
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

If possible, please give the name of each medication, amount taken, and purpose

Comments :

Vaccines or Inoculations	Comments:
Have you received these over the years? All answers are fully confidential **VERY IMPORTANT. Your complete answers will help us to better diagnose problems. If known, please tell us when with comments regarding reactions, etc.** COVID 19 - FIRST SHOT Please indicate BRAND NAME (Johnson & Johnson, AstraZeneca, Moderna, Pfizer, BioNtech, Sinovac, etc.) Please also indicate DATE and PLACE or CLINIC the shot was received (very important). COVID 19 - SECOND SHOT COVID 19 - FIRST BOOSTER SHOT COVID 19 - SECOND BOOSTER SHOT COVID 19 - THIRD BOOSTER COVID 19 - FOURTH BOOSTER, or more How many times have you taken the PCR / Swab ? Chickenpox (Varicella) Cholera Current flu vaccination every flu season Diphtheria-tetanus-pertussis (DTP) vaccine Haemophilus influenzae type b (Hib) Hepatitis A Hepatitis B Hepatitis C 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	

## Antibiotics in the Past 10 Years **These questions are very important for proper diagnosis of disease, because many antiobiotics can affect immunities for 5 years or longer.** 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.	**Comments:**

PART SEVEN : THERAPIES PAST AND PRESENT ...

Happiness and Well Being	Comments:
Please tick the boxes that may apply Are you generally happy and content? What are your strengths? What are your weaknesses? Suffer from depression? Suffer from anxiety? Do you take medications for depression or anxiety? Easily angered? Practice any form of mind centering, such as meditation or quiet time? Other answer not listed above, please comment	

Therapies Received in the Past 2 Years or Now Receiving	Comments:
Please add when and why taken Acupuncture Aromatherapy Chelation therapy Colonic therapy Detoxing Cannabis Chemotherapy Herbal medicine Homeopathy Naturopathy Oxygen therapy Prolo Therapy Radiation Therapy Reiki Vitamin C infusions Other therapy not on this list Never or none of the above	

Surgeries and Operations	Comments:
Please add when and why performed, plus results Appendix removed 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	Comments:
Please check all that apply. Please comment about when and why. Oral anti-fungal medicnes? Topical anti-fungals? Not sure or other medicine, please explain Never or none of the above	

Parasites	Comments:
Have you in the past 5 years been treated for or presently have parasites? Please check all that apply below. Please add when and how remedied Have you in the past 5 years been treated for or presently have parasites? Please check all that apply below. Please add when and how remedied Treated for digetive parasites? If so when and how. Did the treatment work? 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

Or other comments or requests. Please take your time here, and let us know more about you

Comments:

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).