



Questionnaire Qi-Machine No.2





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4. Are you often tired or exhausted?

very often	often	occasionally	rare	never

5. How do you feel about your sleep quality (deep sleep, recovery after sleep, awake phases, etc.)? (1 = very bad, 10 = very good)

1	2	3	4	5	6	7	8	9	10

6. How often do you have a headache or migraine?

very often	often	occasionally	rare	never

7. How do you rate your coffee and / or caffeine intake (also black tea, guarana, etc.)? (1 = very low, 10 = very high)

1	2	3	4	5	6	7	8	9	10

8. How often do you take painkillers or tranquilizers?

very often	often	occasionally	rare	never

9. How often do you consume alcohol? (1 = never, 10 = more than 3 times a week)

more than 3 times a week	Once a week	Once a month	occasionally	never

10. How do you feel about the water quality (tap or bottled water) in your house?
(1 = very bad 10 = very good)

1	2	3	4	5	6	7	8	9	10

11. Is radiation exposure a problem for you? (Radiation-related symptoms such as headache, restlessness, etc.)

very often	often	occasionally	rare	never

12. How stressful do you perceive phone calls with a mobile phone? (1 = very stressful, 10 = not disturbing)

1	2	3	4	5	6	7	8	9	10

13. How do you assess the health of your pets?

very well	well	mediocre	bad	very bad

Do you have one or more of the following diseases? ☐ no
(please tick as appropriate)

- | | | |
|--|--|--|
| <input type="checkbox"/> heart disease | <input type="checkbox"/> circulatory diseases | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> bypass / stent | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Blood clotting disorder | <input type="checkbox"/> immunodeficiency (HIV / AIDS) | <input type="checkbox"/> jaundice |
| <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> chronic lung disease | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> Renal impairment | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> eye disease |
| <input type="checkbox"/> Diabetes Type I or II | <input type="checkbox"/> gastrointestinal diseases | <input type="checkbox"/> tumor disease |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> epilepsy | <input type="checkbox"/> Alzheimer |

other diseases: _____

