Quick Start — The Method on One Page

When a case feels overwhelming, return to these steps.

1. **Start:** Confirm the client's concern, safety, consent, scope and relevant medical care.
2. **Clarify:** Write one session question and the context that may affect interpretation.
3. **Assemble:** Group client experience, clinical context, scan observations and response over time. Mark dependent outputs and contradictions.
4. **Name:** Describe one provisional working pattern without claiming a diagnosis or root cause.
5. **Choose:** Select one priority using safety, relevance, support, feasibility, burden and reviewability.
6. **Translate:** Build the minimum coherent session. Define what will not be done.
7. **Reassess:** Review client-centred outcomes before adding. Continue, modify, pause or refer.
8. **Document:** Record observations, interpretation, uncertainty, action, deferred items and the next decision.

Use three stop questions throughout: Do I already have enough information for the next responsible decision? Would another screen change the priority? Am I adding this because the case supports it or because uncertainty feels uncomfortable?

The central sentence of the method remains: **The software gives you information. Practitioner reasoning turns that information into a responsible plan.**

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Chapter 1 — Begin With the Person, Not the Scan

A scan result has no useful meaning in isolation. It belongs to a person with a history, priorities, beliefs, resources, medications, diagnoses, stressors, and expectations. If the practitioner opens the software before understanding why the client came, the session is at risk of becoming device-led rather than person-centred.

Start with the presenting concern in the client's own words. Ask what has changed, how long it has been present, what makes it better or worse, what has already been investigated, and what outcome would feel meaningful. Record current medical care, medication, supplements, allergies, pregnancy status where relevant, and recent tests. Do not use the scan to contradict established medical findings.

Three questions anchor the first review:

1. What does the client want help understanding or supporting?
2. What information is already known through appropriate clinical assessment?
3. What would make this case unsafe or inappropriate for bioresonance support alone?

The scan question should follow the client's question. A client concerned about persistent fatigue does not need every displayed variation turned into a separate problem. The practitioner needs to ask whether the scan offers a coherent observation relevant to the client's experience—and whether that observation is sufficiently consistent to influence a conservative plan.

Practitioner checkpoint

Before opening the report, write a one-sentence case question: "For this session, I need to understand…" If the sentence contains four or five unrelated aims, narrow it.

What not to conclude

Do not assume that a visually prominent result is the cause of the client's symptoms. Prominence within software is not the same as diagnostic validity, clinical urgency, or biological causation.

1.1 The consultation has two information systems

Every consultation contains at least two information systems. The first is the person's lived experience: symptoms, function, history, priorities, fears, resources, medical care and goals. The second is the device output: anatomical screens, markers, graphs, ranked comparisons and software-generated suggestions. Good reasoning does not force one system to replace the other. It asks where they agree, where they differ and what level of confidence is justified.

The client's account should be gathered before the practitioner becomes absorbed in the scan. Once a striking image appears, confirmation bias can quietly reshape later questions. A practitioner may begin asking only about symptoms that fit the screen and overlook information that contradicts it. Beginning with the person creates an independent record against which the scan can later be compared.

1.2 Build a functional baseline

A useful baseline is short enough to repeat. Select two to four outcomes that the client can observe without a device: sleep continuity, bowel pattern, pain interference, energy stability, ability to concentrate, tolerance of meals, skin discomfort or another function relevant to the presenting concern. Use the client's own language and, where helpful, a simple 0–10 scale. The purpose is not to turn every consultation into formal research. It is to stop the screen from becoming the only measure of progress.

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1.3 The opening five minutes

Before scanning, establish five things: the main concern, its time course, what has changed recently, what medical assessment has already occurred and what a useful outcome would look like. Ask what the client most wants help understanding. Ask what they can realistically change. These questions create the boundaries for the session.

Practice example. A client says, "My digestion is terrible." A scan-first approach may investigate every digestive structure. A person-first approach clarifies that the main problem is urgent bowel movements after lunch, beginning after antibiotics, with unintentional weight loss. The weight loss changes the safety assessment; the timing and antibiotic history shape the working questions; and the client's goal becomes eating lunch without fear. The person has already changed the reasoning before the first screen opens.

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Chapter 3 — Safety, Scope, and Referral

No prioritisation framework is responsible without a safety gate. Before discussing energetic patterns, ask whether the client's presentation requires conventional assessment.

Potential referral indicators include acute or severe symptoms, sudden neurological changes, chest pain, difficulty breathing, severe dehydration, uncontrolled bleeding, signs of a serious allergic reaction, suicidal thoughts, unexplained significant weight loss, persistent fever, a new or rapidly changing lump, severe pain, or deterioration despite support. This list is not exhaustive. Local emergency guidance and professional scope always take precedence.

Referral does not mean rejecting the client. It means recognising that the correct next step may be outside the device and outside the practitioner. Supportive care can sometimes continue alongside appropriate medical care, provided it is safe, lawful, coordinated, and not represented as a replacement.

Use clear language: "This result is not a diagnosis. Because of the symptoms you have described, I recommend that you seek medical assessment before we proceed." Document what the client reported, what you advised, and whether the client understood.

Practitioners must also recognise commercial pressure. A desire to provide value can quietly become a reason to keep working when referral is more appropriate. Ethical value is not measured by the number of programs run. Sometimes the most valuable action is restraint.

The safety gate

Proceed only when all four statements are true:

1. No immediate red flag has been identified.
2. The client understands the non-diagnostic nature of the service.
3. The proposed support falls within the practitioner's competence and legal scope.
4. Appropriate medical care is not being delayed or discouraged.

3.1 Safety is an active reasoning process

Safety is not a disclaimer placed at the front of a book. It is a repeated decision throughout the consultation. New information can change the safety picture: a recent medication change, pregnancy, severe pain, neurological symptoms, dehydration, rapidly worsening function, significant bleeding or a client's decision to delay medical care because of a scan interpretation. The practitioner must remain willing to pause the energetic workflow when the situation changes.

3.2 Red flags and uncertainty

A red flag does not require the practitioner to diagnose the condition behind it. It requires recognition that timely medical assessment may be needed. If the meaning of a symptom is uncertain, the safest response is not to create a confident energetic explanation. Document the concern, explain the limit of the service and recommend the appropriate level of conventional assessment.

3.3 Scope has three dimensions

Legal scope concerns what the practitioner is permitted to do in the relevant jurisdiction. **Competence scope** concerns what this individual practitioner is trained and able to do safely. **Service scope** concerns what the client has consented to receive. An action can be lawful yet outside the practitioner's competence, or within competence yet outside the agreed service.

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