CLIENT HISTORY
LIVE AND DRY BLOOD ANALYSIS

Surname ____ Given Name(s) __________________________________

Gender: ❑ F ❑ M Birthdate ______________________ Place of Birth _________________________________

Address: ____

City _____________________________________ Province _______________ Postal Code ___________________

Cell Phone (_____) ________________________________ Home Phone (_____) ______________________________

Email____ Business Phone (_____) ___________________

What is your occupation ___________________ How long? __________ years

Emergency Contact Information:

____

What other therapies are you using at this time (e.g., massage, chiropractic)?

____ ____

Blood Type ____ Time of last meal/snack ___________

Give a diet summary of a typical 1 day period:

Breakfast: ____

Lunch: ____

Dinner:____

Snacks / Drinks: ____

Have you ever had a bad fall or been in a car accident? ❑ Yes When/Details________________________
❑ No

Please indicate your usage level of the following:

	None	Light	Moderate	Heavy
Salt	❑	❑	❑	❑
Sugar	❑	❑	❑	❑
Carbonated bev.	❑	❑	❑	❑
Caffeine	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Alcohol	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Water	❑	❑	❑	❑
Computer use	❑	❑	❑	❑
Cell phone	❑	❑	❑	❑
Cordless phone	❑	❑	❑	❑
Video games	❑	❑	❑	❑
Wireless internet	❑ No	❑ Yes		
Satellite	❑ No	❑ Yes		

Do you live near farming? ❑ No ❑ Yes What kind? (e.g., crops, livestock) ________________________

How old is your home? ______ yrs. How long have you lived there?______

Have you done any renovations recently (painting, flooring)? ❑ No ❑ Yes What kind? _____________

Do you have a fireplace? ❑ woodstove ❑ gas ❑ electric

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Do you live near: nuclear reactor plant? ❑ Yes ❑ No
military base? ❑ Yes ❑ No

Around your home or workplace, are there: power lines or grid? ❑ Yes ❑ No
transformers? ❑ Yes ❑ No

Do you use: a microwave ❑ Yes ❑ No
electric blanket ❑ Yes ❑ No
waterbed ❑ Yes ❑ No

Do you have a T.V. or computer in your bedroom? ❑ Yes ❑ No

Do you have fillings? ❑ No ❑ Yes How many _____ Since when? _____________ Type_______________

Do you have other dental work (e.g., bridge, partial, dentures, root canal)? ❑ No ❑ Yes Which tooth_______

Do you use aluminum pots or foil paper? ❑ Yes ❑ No

What type or brand of deodorant do you use? ____

Have you ever taken any contraceptive medication? ❑ Yes How long? _____
❑ No

Do you take or have you taken hormone replacement therapy? ❑ Yes ❑ No

Have you had vaccinations? ❑ Yes ❑ No

Do you have any tattoos? ❑ Yes ❑ No How many? __________

What drugs have you taken (over the counter or recreational)? ❑ Advil ❑ Sinutab ❑ Marijuana

❑ other / prescription

____

List all nutritional supplementations you are using at this time (include how often, and how much):

____

____

Have you had surgery? ❑ Yes When / Details____
❑ No

In the past year, have you had any lab tests, x-rays or other diagnostic test? ❑ Yes Details______________
❑ No

Do you have allergies or intolerances? Environmental ❑ Yes ❑ No Details:_________________________
Food ❑ Yes ❑ No Details:_________________________
Other ❑ Yes ❑ No Details:_________________________

Do you have digestive problems? ❑ Bloating ❑ Gas ❑ Heartburn ❑ Other ___________________

Bowel Movement – How many bowel movements a day? ________ Consistency: Normal, Loose or Hard?

Is your occupation stressful? ❑ Yes ❑ No Details: _________________________________

Are there any stressful relationships with co-workers, friends, or family members? ❑ Yes ❑ No

Details: ____

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Do you have problems with any of the following:

	Yes	No	Details
Endocrine (ex. Diabetes, hypoglycemic, menopause, thyroid)	❑	❑	________________
Urinary (ex. Kidney disease, urinary problems)	❑	❑	________________
Cardiovascular (ex. high/low blood pressure, heart disease, varicose veins)	❑	❑	________________
Immune & Lymphatic (ex. arthritis, chronic fatigue, HIV, allergies)	❑	❑	________________
Musculoskeletal (ex. osteoporosis, fibromyalgia, back pain, scoliosis, joint pain)	❑	❑	________________
Respiratory (ex. asthma, emphysema, shortness of breath)	❑	❑	________________
Nervous (ex. vision, hearing, nerve pain, mental / emotional, numbness)	❑	❑	________________
Reproductive (ex. PMS, endometriosis, prostate)	❑	❑	________________
Digestive (ex. constipation, diarrhea, Crohn's, colitis, diverticulitis)	❑	❑	________________
Integumentary / Skin (ex. psoriasis, eczema, warts, rashes, hives, itching)	❑	❑	________________

Describe sleep patterns (ex. number of hours, time of day) ____

____

List all other symptoms, ailments, and health concerns not mentioned above:

____

____

Give details of your family medical history:

____

____

Instructions and Directions for Live and Dry Blood Analysis

1) Make sure you drink lots of water before your blood analysis. Hydration is important and allows for an accurate reading.
2) Do not eat protein or fat for a minimum of 3-4 hours prior to your appointment.
3) You can eat fruits and vegetables.
4) You are welcome to bring a snack. Protein and fat can be eaten after the blood sample has been taken.

Please allow a minimum of 24 hours to cancel and reschedule your appointment.

Consent to Live Blood Analysis:

I am participating in a visual session of my blood, so that I may learn its composition and the nutritional action it has on my body. I understand that the visual session of my blood is for purpose of nutritional information only. I am aware that this should not be considered as medical diagnostic. Furthermore, this test is not to be a substitute for any other laboratory examination. The information received is solely for educational purposes only.

Signature ________________________________ Date ____________________