

Healthworks

NUTRITION CENTRE

MICROSCOPIC LIVE BLOOD CELL ASSESSMENT

Name: _____ Date: _____

Check the box of your preferred method of contact

Email: _____ Date of Birth: ___/___/___ Sex: M / F

Cell Phone: _____ Other Phone: _____ Home Work

Address: _____ City: _____ Prov.: _____ Postal Code: _____

How did you find us? Name: _____ Facebook Instagram Internet search Other

H I S T O R Y	List <u>PAST</u> major health problems and surgeries. Give dates wherever possible.	Were you born by C-section? Y / N Do you have any allergies? Y / N List below:
	Have you ever lived in a home with mold? Y / N Dates & duration: _____	How many silver/mercury fillings do you have? ____ How many times have you been on antibiotics in your life? 0 / 1 / 2 / 3 / 4+
Have you ever done any cleanses? Y / N Check all: <input type="radio"/> Yeast <input type="radio"/> Liver <input type="radio"/> Colon <input type="radio"/> Kidney		

Occupation: _____ Hrs/week: _____ Retired	L I F E S T Y L E
Are you exposed to any work-related chemicals? Y / N Name: _____	
How many hours/day do you have a cell phone/laptop on or very close to your body? Circle: 1-3 / 4-5 / 6-8 / 9+	
How would you rate your stress levels in the past 6 months: low / medium / high	
How many hours/day are you sitting? ____/day	How often do you smoke the following?
How many hours/day are you moving? ____/day	Cigarettes ____/day ____years
How many hours/week do you sweat while exercising? ____/day	Weed ____/day ____years
Describe your workout: _____	Do you colour your hair? Y / N

F L U I D S	How many litres of water do you drink each day? ____	How often do you drink the following beverages.
	Please check the type of water you drink below.	Coffee ____/day
	<input type="radio"/> Distilled <input type="radio"/> Well <input type="radio"/> Filtered <input type="radio"/> Tap <input type="radio"/> Spring <input type="radio"/> Reverse Osmosis	Pop/Soda ____/day
	How often do you drink out of plastic water bottles? ____/day	Wine ____/week Organic? Y / N
		Beer ____/week Organic? Y / N
		Alcohol ____/week

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Describe what you typically eat and drink for the following meals

Breakfast:

Lunch:

Supper:

Snacks:

What percent of your diet is organic? _____%

How often do you have bowel movements? 1 / 2 / 3 / 4 / Less than once

How is your energy level? Good / Fair / Poor

How would describe your sleep? Sufficient / adequate / lacking

Have you had any recent or drastic weight change?

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Current Medications (prescribed or non-prescribed):

Current Herbal/Vitamin Supplements:

What are your current health concerns? Which of these concerns is most immediate to you?

CONSENT AND ACKNOWLEDGMENT

I, the undersigned, hereby understand and acknowledge that Grant M. Derkatz is not a medical practitioner and in particular that he:

- A) does not hold himself out as being able to diagnose, treat, operate or prescribe for any human disease, pain, injury, disability or physical condition;
- B) does not offer or undertake by any means or methods to diagnose, treat, operate, prescribe for any human disease, pain, injury, disability or physical condition, and;
- C) cannot and will not give medical advice.

I, the undersigned, hereby confirm and acknowledge:

- A) all information from, or communication with, Grant M. Derkatz are at my own request, with full knowledge of the above particulars, and;
- B) no guarantees have been made to me concerning the results that may be obtained as a result of my consultation with Grant M. Derkatz.

Dated this _____ day of _____, 20_____.

_____ Signature

_____ (Please print name)

_____ Parent/Guardian Signature (If under 18 years old)

The use of any recording devices is strictly prohibited WITHOUT the express written consent of Healthworks Nutrition Centre

Healthworks Nutrition Centre will not share your health information without your consent.