Evaluation Sheet- Live And Dry Blood Analysis

Surname_____ Given Name_____

Gender: ❑ F ❑ M Date of Birth _____19___ Place of Birth _____

Address _____

City _____ Province_____

Postal Code _____ Telephone: Res. (_____) _____

Email_____ Bus. (_____)_____

Blood Type _____ Time of last meal/snack _____

What is your occupation _____ How long? _____ years

Give a diet summary of a typical 1 day period:

Breakfast: _____ Lunch: _____ Dinner:_____

Snacks / Drinks: _____

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? ❑ Yes ❑ No If yes, what kind? Agricultural, dairy? _____

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

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

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

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 digestive problems? ❑ Bloating ❑ Gas ❑ Heartburn

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

Do you have a bridge/partial/dentures/have had a root canal? ❑ Yes ❑ No

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 inoculations? ❑ Yes ❑ No

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

❑ other / prescription _____

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

Do you have allergies or intolerances? environmental ❑ Yes ❑ No Details:_____
food ❑ Yes ❑ No Details:_____
other ❑ Yes ❑ No Details:_____

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

_____

_____

Do you have problems with any of the following:

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

List all other symptoms and ailments not mentioned above:

_____

_____

Give details of your family medical history:

_____

_____

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 _____