Miranda Naturopathic Clinic

Florence Caie, CNP, RHNP

Registered Holistic Nutritionist
Live Blood Cell Analyst

Health Evaluation Profile for Live Blood Cell Analysis

Name: _____	How did you hear about Live Blood Cell? _____
Address: _____	Home #: _____
_____	Work #: _____
City:_____ Prov: _____ Postal code: _____	Mobile #: _____
Date of birth: _____ Age: _____	Can we leave messages? Yes No - If so, where: H W M
Occupation: _____	Email : _____

Indicate your main health concerns – in order of importance to you:

For how long have you had this problem?

1.- _____ _____
2.- _____ _____
3.- _____ _____
4.- _____ _____

List all prescription medications you are taking:

Why are you taking it?

1.- _____ _____
2.- _____ _____
3.- _____ _____
4.- _____ _____

NUTRITION + DIET + LIFESTYLE

On a scale of 1 to 10 (1 being the lowest) rate your: Energy level _____ Stress level _____	Weight: _____ Height: _____ Maximum weight: _____ When: _____
Describe your relationship with food: Excellent Good Poor Food is my enemy How many fruits & vegetables do you eat per day? _____ How do you clean them? Water hydrogen peroxide Other: _____ Do you like to cook? Yes No	Circle what your diet consists of: Organic produce Vegan Vegetarian Mixed food diet (animal & vegetable) List specific food restrictions, allergies or intolerances: _____ _____ _____ _____
Circle your eating habits: On the run Skip meals Skip breakfast Eat meals & snacks Eat fast food Graze (small freq) Other: _____	Indicate how much you consume per day or per week: Caffeine _____ Alcohol _____ Carbonated beverages _____ Diet drinks _____ Cigarettes _____ Recreational drugs _____

How many hours do you sleep per night? _____ Do you wake up feeling rested? Yes NO Do you have pets: No Yes _____	What type of exercise do you do? _____ _____ How often? _____
How many glasses of water do you drink daily? _____ How many herbal teas do you drink daily? _____	What is the source of your cooking & drinking water? Filtered ( ) Tap ( ) Bottled ( ) Reverse Osmosis ( )
Do you have a bowel movement every day? _____ Do you have a tendency to constipate? Yes No Do you have a tendency to get diarrhea or loose stools? Yes No	Have you ever been on antibiotics? Yes No How often approximately? _____ For what reason?_____

Rate each of the following symptoms based upon your typical heath profile and add up your score.

POINT/SCALE 0 *Never* 1 *Occasionally, effect is not severe* 2 Occasionally*, effect is severe*
3 Frequently, but not severe* *4 Frequently, and is severe

HEAD **Headaches** **Faintness** **Dizziness** **Insomnia** **_____ TOTAL**	**NOSE** **Stuffy nose** **Sinus prob.** **Hay fever** **Sneezing** **Exces.Mucus** **_____ TOTAL**	**HEART** **Irregular or skipped heartbeat.** **Rapid or Pounding heartbeat.** **_____ TOTAL**	**EARS** **Itchy ears** **Earaches** **Ear Infec.** **Ear Drainage** **Ringing** **_____ TOTAL**
EYES **Watery or Itchy** **Swollen, sticky or reddened lids** **Blurred vision** **_____ TOTAL**	**MOUTH/ THROAT** **Chronic cough** **Gagging,** **Clear throat** **Canker sores** **Discoloured Gums, lips** **_____ TOTAL**	**SKIN** **Acne** **Hives, rashes, Dry skin** **Flushing, Hot flashes** **Excessive sweating** **_____ TOTAL**	**LUNGS** **Chest congest.** **Asthma** **Bronchitis** **Shortness of breath** **_____ TOTAL**
DIGESTION **Nausea** **Vomiting** **Diarrhea** **Constipation** **Bloated** **Passing gas** **Heartburn** **Stomach pain** **_____ TOTAL**	**JOINTS/ MUSCLE** **Pain or aches in joints** **Arthritis** **Stiffness** **_____ TOTAL**	**WEIGHT** **Binge eating** **Cravings** **Excessive wt** **Compulsive Eating** **Water retention** **_____ TOTAL**	**ENERGY** **Fatigue** **Apathy** **Lethargy** **Hyperactivity** **Restlessness** **_____ TOTAL**
MIND **Poor memory** **Confusion** **Poor concentration** **Diff. in making decisions** **Slurred speech** **Learning disabilities** **____ TOTAL**	**EMOTIONS** **Mood swings** **Anger** **Fear** **Nervousness** **Depression** **Aggression** **_____ TOTAL**	**OTHER** **Frequent illness** **Frequent or urgent urination** **Genital itch or discharge** **_____ TOTAL**	**STRESS** **Stressful job** **Stressful relationships with family, friends, coworkers** **_____ TOTAL**