Susan Colacicco
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 massages? Yes No - If so, where: H W M
Occupation: ______________________	Email : ______________________

Would you like to receive "Dr. Miranda's weekly health tips"? Yes No

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? ________________________________

Circle each of the following symptoms based upon your typical heath profile.

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

Date____________________________ Signature____