Healthworks
NUTRITION CENTRE

MICROSCOPIC LIVE BLOOD CELL ASSESSMENT

Name:____ Date:____________________

Check the box of your preferred method of contact

☐ Email:_______________________________________ Date of Birth:__mo/day/year__ Sex: M / F

☐ Cell Phone: _____________________ Other Phone: ______________________ O Home O Work

Address: ___________________________ City:_______________ Prov.:________ Postal Code:________

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

HISTORY

List *PAST* 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:

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 lived in a home with mold? Y / N Dates & duration: ______________________

Have you ever done any cleanses? Y / N Check all: O Yeast O Liver O Colon O Kidney

LIFESTYLE

Occupation: Hrs/week: _____ Retired

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 many hours/day are you moving? ______/day

How many hours/week do you sweat while exercising? ______/day

Describe your workout:

How often do you smoke the following?

Cigarettes _____/day ____years

Weed _____/day ____years

Do you colour your hair? Y / N

FLUIDS

How many litres of water do you drink each day? _____

Please check the type of water you drink below.

O Distilled O Well

O Filtered O Tap

O Spring O Reverse Osmosis

How often do you drink out of plastic water bottles? __/day

How often do you drink the following beverages.

Coffee _____/day

Pop/Soda _____/day

Wine _____/week Organic? Y / N

Beer _____/week Organic? Y / N

Alcohol _____/week

FOOD & WASTE

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

CURRENT

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?

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.