Microscopy Health Evaluation Profile

Thank you for your interest in having a blood cell analysis completed. The evaluation includes:

- analysis of the blood, which represents the physical conditions and nutritional requirements
- the combined effects of diet, lifestyle, environmental and emotional stressors

This questionnaire helps to identify the potential relationship between traumas that have been sustained and the 5 underlying causes: chemicals, diet, radiation, emotions or infection foci.
Please be as honest and as thorough as you can.

Live Cell Microscopy Disclaimer

I understand that Nutritional and Live Cell Microscopy are screenings for educational purposes only and that the educator, Rev. Dr. Jacqueline R Bowman, MMSc., PhD., conducting these sessions is not a medical doctor. Jacqueline R Bowman is a Certified Reiki Master Practitioner, TBM (Total Body Modification) Practitioner, Intuitive, Transpersonal Counselor (PhD), Ordained Minister, and Live Cell Microscopist.
The information being sought is of a nutritional nature and is not for medical diagnosis or treatment. LCM is a terrain assessment for educational purposes only. Rev. Jacqueline cannot tell if disease is present. A toxic terrain can allow a disease process, so it is our goal to assist you to manage that terrain as prevention only.
Any suggested nutrition is not intended as a primary therapy for any disease or symptom. Any added schedule of food supplementation is provided solely to upgrade and enhance the quality of food delivered through the diet.
I understand that my specimen may be utilized confidentially for education or research and statistical gathering purposes.
I hereby certify that I am here on this and any subsequent visit, solely on my own behalf and not as any federal, provincial or municipal agent on a mission of entrapment or investigation, via any and all outlets including media and print.

Name _____ / for _____
(underage client)
Signature _____ Date_____

Personal information:

Name:	Phone Number: (H) (cell)
M [ ] F [ ]	E-mail address:
Age:	Address:
Referred By:	
Blood Type: A B AB O	Birth date:
Forwarding results to care practitioner / team. Specify direction for further disclosure.	

List paternal family diseases:	
List maternal family diseases:	
Do you have pets?	Y [ ] N [ ] What kind?
What type of cardio exercise do you do?	
How often and duration?	
What type of weight training do you do?	
How often and duration?	
Do you experience digestive difficulties? (ie. bloating, constipation, gas)	Y [ ] N [ ] Describe:
Do you have a bowel movement every day?	Y [ ] N [ ] How many per day?
List any food or environmental allergies you have:	
Provide complete details about your entire health history. Be as specific as possible. Use the back of the sheet if necessary.	
Have you ever been hospitalized for surgery?	Y [ ] N [ ] Approximately when and what for?
List all supplementation (vitamins, minerals, herbs) you are taking:	
List all prescription medication you are taking and why you are taking it:	
Describe any health issues/problems you are currently experiencing. Specify your main concern.	
Is there anything that will get in the way of following a treatment plan in order to achieve results?	

Diet

# of coffees per day?	
For how many years?	
If you quit, how long ago?	
# of black teas per day?	
For how many years?	
If you quit, how long ago?	
# of carbonated beverages per day?	Any diet drinks? Y [ ] N[ ]
For how many years?	
If you quit, how long ago?	
Do you consume alcohol?	Y [ ] N[ ] How much and how often:
How many ounces of water do you drink per day?	
What is the source of your drinking water?	Filtered [ ] Tap [ ] Reverse osmosis [ ] Bottled [ ]
How many grams of chocolate do you eat per week?	

How many fruits do you eat per day?	
How many vegetables do you eat per day?	
Are the fruits and vegetables organic?	Y [ ] N [ ] Sometimes [ ]
What do you wash non-organic in?	Veggie wash [ ] Peroxide solution [ ] Water [ ] Other [ ]
Provide any other information that may be relevant, but hasn't been covered in regard to diet.	

Emotions:

Is your occupation stressful?	Y [ ] N [ ] Describe:
Are there any stressful relationships with coworkers/management?	Y [ ] N [ ] Describe:
Are there any stressful relationships with family members?	Y [ ] N [ ] Describe:
Are there any stressful relationships with friends?	Y [ ] N [ ] Describe:
Describe any other stressful situations/relationships that are in addition to those mentioned above:	
Provide any other information that may be relevant, but hasn't been covered in regard to emotions.	

Radiations:

Have you ever lived near nuclear reactors or military bases?	Y [ ] N [ ] Currently? Y [ ] N [ ]
For how long?	
How many miles away?	
Any high-tension lines or step-down transformers near your home or work?	Y [ ] N [ ] How many miles away?
Do you use any of the following:	Micro-wave [ ] Electric blanket [ ] Water bed [ ]
Are you exposed to fluorescent lights at work or home?	Y [ ] N [ ]
Do you use a computer?	Y [ ] N [ ] How long each day?
Do you use a cell phone?	Y [ ] N [ ] How long each day?
How often do you travel by plane?	
When was the last time?	

Chemicals:

Where did you live while growing up? (City, country)	
What type of environment do you work in?	Office [ ] Factory [ ] Other [ ] If other, describe:
Occupation:	
Any tattoos?	
How many cigarettes do you smoke per day?	
For how many years?	
If you quit, how long ago?	
How many metal dental fillings do you have?	
Have you had any removed?	Y [ ] N [ ]
How many?	
Date of most recent removal?	
How many root canals do you have?	
Date of most recent dental proceedure?	
Do you have crowns or other metals (ie. braces, partials,	Y [ ] N [ ] What type?

retainers)	
Do you, or have you used aluminum cookware?	Y [ ] N [ ] How recently?
Do you use antiperspirants that contain aluminum?	Y [ ] N [ ]
Do you use antacids?	Y [ ] N [ ] How often?
Are you now, or have you ever, taken birth control pills?	Y [ ] N [ ] How many years?
If you quit, how long ago?	
Have you ever been on hormone replacement therapy?	Y [ ] N [ ] Currently?
How many years?	
If you quit, how long ago?	
Have you ever had shots/vaccinations? (including flu shot)	Y [ ] N [ ]
Which ones?	
How long ago?	
What drugs have you taken during your life? (prescription, over-the-counter, and "recreational"). Note: this is in addition to what you are taking currently, which was described on page 1)	
Have you ever been on antibiotics?	Y [ ] N [ ]
How often?	
For what reasons?	
Date of last prescription	
Type?	
For what?	
Have you ever lived near any farms or large agricultural projects?	Y [ ] N [ ]
What kind (dairy, vegetable, orchard, etc.)?	
When?	
Do you dryclean your clothes?	Y [ ] N [ ] How often?
Do you live in pre-fab housing, ie. mobile or modular home?	Y [ ] N [ ] How old is the home?
Any renovations in your home within past 12 months? (ie. paint, new carpets)	
How is your home heated?	Wood stove? [ ] Gas? [ ] Electric? [ ] Other? [ ]
List cosmetics/make-up you use regularly?	
Natural products?	Y [ ] N [ ] Manufacturers:
What household products are you exposed to?	Bleach [ ] Toilet Cleaners [ ] Air Freshener [ ] All Purpose cleaners [ ] Lawn or gardening chemicals [ ] Other chemicals?

Notes: