

Biofield & Microscopy Health Evaluation Profile



Thank you for your interest in having a Live Cell analysis completed. If you are not choosing a Live Cell Analysis today, this intake allows for a deeper understanding for questions and corrections within your biofield.

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 & Biofield Disclaimer and Policies.

- I have signed and attached the disclaimer **NATUROTHERAPY w/ TRANSPERSONAL COUNSEL for Darkfield Microscopy (Live Blood Analysis) and Biofield (ft Reiki & TBM) Therapy. Including Telehealth for Remote/Distance Sessions.**
- I have signed and attached my acknowledgment of **BUSINESS POLICIES** for these sessions.

Name _____ / for _____

(underage client)

Signature _____ Date _____

Personal information:

Name:	Phone Number: (H) _____ (Cell) _____
M [] F []	E-mail address: _____
Age:	Address: _____
Birth date:	
Referred by::	
Forwarding results to care practitioner / team. Specify direction for further disclosure.	

Personal Info Cont'd.

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 []
Are you exposed to fluorescent lights at work or home?	Y [] N []	Water bed []
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 procedure?	
Do you have crowns or other metals (ie. braces, partials, retainers)	Y [] N [] What type?
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: Continue onto back of page if needed

