***One Body Health & Wellness***

Chantelle Hinze BScN, RN, ROHP, RNCP

Certified Live Cell Microscopist

NAET Practitioner

onebodyhw@gmail.com

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| Last Name | First Name | Date |

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| Address | Phone (home) |
| City | Phone (cell) |
| Province | Phone (work) |
| Postal Code | Email |
| Date of Birth | Occupation |

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| Reason for visit | Western medical diagnosis (if applicable) |
| When did symptoms first begin? | Are you currently being treated? Yes No |
| List other medical treatments received for this issue | Results of treatment |
| Family Physician Name | Physician Phone |
| Emergency Contact Name | Emergency Phone |
| List all prescriptions medications, over the counter drugs, supplements, herbs you currently take. | Reason for medication/ supplement |
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| List all allergies (food, drug, environmental etc.) |  |
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| Health History (Please check the boxes that are applicable. Add dates and comments as necessary.) |

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|  | Heart Disease |  | Liver Disease |  | Kidney Disease |  | Lung Disease |  | Diabetes |
|  | Stroke |  | Hepatitis |  | Hearing Issues |  | Asthma |  | Depression |
|  | Blood Pressure  Low / High |  | Headaches  Migraines |  | Back Pain |  | Allergies |  | Bleeding Disorder |
|  | Thyroid Issues  Type: |  | Seizures |  | Osteoporosis |  | Skin Disease  Type: |  | Chronic Fatigue |
|  | Cancer (specify) |  | Digestive Issues |  | Urinary Issues (specify) |  | Arthritis (type) |  | Anemia |
|  | HIV/AIDS |  | Tinnitus |  | Infertility |  | Shortness of Breath |  | Hemorrhoids |
|  | Sexually Transmitted Disease |  | Prostate Issues |  | Impotence |  | Chronic Cough |  | Fibromyalgia |

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|  | Dental Health  Any? Amalgam? (silver fillings) \_\_\_\_\_\_\_ Root Canals?\_\_\_\_\_\_ Crowns?\_\_\_\_\_\_\_ |

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| Check all the symptoms that you have experienced in the past 12 months. |

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|  | Chest Pain |  | Irritability / Frustration |  | Memory Loss |  | Frequent Colds/ Flus |  | Fatigue |
|  | Night Sweats |  | Vision Changes |  | Loss of Bladder Control |  | Sore Throat / Hoarseness |  | Bloating  Gas |
|  | Heart Palpitation |  | Numbness/Tingling limbs / hands / feet |  | Frequent Urination |  | Spontaneous Perspiration |  | Weight Gain  Weight Loss |
|  | Agitation/ Restlessness |  | Dry / Red / Itchy  Eyes |  | Bladder Infection |  | Grief / Sadness |  | Bruise Easily |
|  | Insomnia / Difficulty Falling Asleep |  | Premenstrual  Syndrome |  | Intolerant to Cold |  | Constipation  Difficult Bowel Movements |  | Unusual Bleeding |
|  | Vivid Dream |  | Bitter Taste in Mouth |  | Low Back Pain  Knee Pain |  | Skin Rashes  Hives  Skin Infections |  | Nausea  Vomiting  Heartburn |
|  | Aversion to Heat |  | Weight Loss  Weight Gain |  | Cold Hands  Cold Feet |  | Snoring |  | Muscular Weakness |
|  | Tongue or Mouth Ulcers |  | Dizziness |  |  |  | Cough  Wet  Dry |  | Appetite  High  Med  Low |
|  | Anxiety |  | Pain or Discomfort Under Ribcage |  | Feeling Fearful |  | Nasal Discharge |  | Tendency to Worry or Overthink |

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| Please list any past serious injuries, broken bones, surgeries, and procedures, including dates. |
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| Daily Life Activities |
| Do you exercise? Yes\_\_\_ No\_\_\_ List type of exercise.  How often? |
| Do you use the following? If so how often? Cigarettes\_\_\_\_\_\_\_ Alcohol \_\_\_\_\_\_\_ Drugs\_\_\_\_\_\_\_  Coffee\_\_\_\_\_\_\_ Pop\_\_\_\_\_\_\_ Water\_\_\_\_\_\_\_\_\_\_    Fruits\_\_\_\_\_\_\_\_ Vegetables\_\_\_\_\_\_\_\_  Have you ever smoked?\_\_\_\_\_\_\_\_ For how long?\_\_\_\_\_\_\_\_\_ When did you quit?\_\_\_\_\_\_\_\_  Where have you lived in your life?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What have you done for work?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How well do you sleep? Circle on the scale of 1-10 (10 being best).  1 2 3 4 5 6 7 8 9 10 |
| How is your daily energy level?  1 2 3 4 5 6 7 8 9 10 |
| Rate your daily stress level. (10 being extremely stressed)  1 2 3 4 5 6 7 8 9 10  Do you have a stressful job? \_\_\_\_\_\_\_  Are there any stressful relationships?\_\_\_\_\_\_\_\_ |
| Do you experience any digestive difficulties? (gas, bloating, etc)  Do you have heart burn, acid reflux or indigestion?\_\_\_\_\_\_\_\_\_\_ Do you use antacids?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How many bowel movements per day? |
| Do you use? Cell phone\_\_\_\_\_ Computer\_\_\_\_\_\_\_\_ Microwave\_\_\_\_\_\_\_ Heated blanket\_\_\_\_\_  Do you live near? Nuclear reactors\_\_\_\_\_\_ Military bases\_\_\_\_\_\_\_ High tension power lines\_\_\_\_\_\_\_  Radioactive Mines (eg, uranium)\_\_\_\_\_\_\_\_\_  Do you use chemicals for cleaning? \_\_\_\_\_\_\_\_\_  Recent Antibiotics?\_\_\_\_\_\_ What for?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Gynecology- For Women Only** |  |
| Age of first menstruation: | Date of last menstruation: |
| Menstrual cycle length (i.e. 26-32 days) | How many days do you bleed in total? |
| Describe your flow: Heavy Average Light | Colour of the blood: (red, dark red, purple, brown, light red etc.) |
| Do you experience pre-menstrual symptoms (PMS)?  Describe: | Do you experience menstrual pain? Yes\_\_\_ No\_\_\_ |

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| **Patient Consent** |
| I the client, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby attest to the following:  That I am here, on this and any subsequent visit, solely on my own behalf and not as an agent of any government agency on a mission of entrapment. I fully understand that Chantelle Hinze is not a medical doctor and I am not here for medical diagnosis or treatment procedures. The services performed by Chantelle Hinze are at all times restricted to consultation on the subject of nutrition for building wellness and DO NOT involve diagnosing, prognosticating, treating or prescribing any remedies for the treatment of a disease, or any act for which a medical licence or medical authorization is required. \_\_\_\_\_ (initial)  I understand that Live Cell demonstration and EAV analysis will provide me with a graphic view of my blood physiology and a demonstration of electrodermal analysis but is NOT a medical test nor is it in any way meant as a diagnosis, treatment, prescription, or cure for any disease, either medical or physical, and is NOT intended as a substitute for conventional medical care by a Medical Doctor or Specialist. I understand that lifestyle, eating habits, exercise, nutritional balance, nutritional supplements and mental state may affect what is seen in the demonstration and therefore results will vary between demonstrations conducted at different times. \_\_\_\_\_ (initial)  I authorize the Live Cell Microscopist, Chantelle Hinze, to use a lancet to obtain a blood specimen required for the demonstration using approved guidelines. I agree to hold harmless, the Live Cell Microscopist, Chantelle Hinze, who performs the demonstration. Any suggested nutritional and lifestyle therapy and supplementation is not intended as a primary treatment for disease, disorders or symptoms but as an added schedule intended to upgrade the quality of foods, diet and assimilation of nutrients. \_\_\_\_\_ (initial) |
| Client Signature: Date: |
| Guardian Signature (if applicable): Date: |
| Practitioner Signature: Date: |

One Body Health & Wellness

Chantelle Hinze RN, BScN

Certified Live Cell Microscopist

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| **One Body Health & Wellness Services** |
| **Service Fee**  **Initial Consultation- New Client- (approx. 75 mins) $180**  Includes Live Cell Microscopy  **1 Hr Follow Up $130**  Includes Live Cell Microscopy OR EAV Analysis depending on needs of client  **30 Min Follow Up $70**  Some Supplements may be recommended at an additional cost  \*\*24 hrs cancellation is required or a 50 percent cancellation fee will be charged\*\*  Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |