Thrive Live Blood Microscopy
New Client Intake Form

IMPORTANT

1. Please **fast for 3 hours** prior to your appointment. No food or drink except water.
2. Please hydrate as much as possible. **Drink at least 3 glasses of water** before your appointment, and void your bladder as necessary.

Questions about your appointment? Contact Carly Del Ciancio at 519-817-0068

Name: Phone: Email: Would you like to receive Carly's top wellness recommendations monthly via email? Y [ ] N [ ] Address: Referred by:	Date of birth: Age: Sex: Blood type A B AB O not sure Marital status: Number of children: Emergency contact name: Relationship: Phone:

○List paternal family diseases:

○List maternal family diseases:

○List any food or environmental **allergies**:
○What type of **exercise** do you do?
How often and duration?
○Do you have a **bowel movement** every day? Y [ ] N [ ]
How many per day?
Do○ you experience **digestive difficulties** (bloating, constipation, gas, diarrhoea)?
Y [ ] N [ ] Describe:

Health History
○Describe any health issues/problems you are currently experiencing]and specify your **main concern:**

○Have you ever been hospitalized for **surgery**? Y [ ] N [ ]
When and what for?

○List all **diagnoses** given by your Physician(s) and the date each diagnosis was given:

○List all **supplementation** (vitamins, minerals, herbs) you are taking:

○List all **prescription medication** you are taking and why you are taking it:

Diet

of **coffees** per day:
For how many years? If you quit, how long ago?

of **carbonated** beverages per day
Any diet drinks?
For how many years? If you quit, how long ago?

○Do you consume **alcohol** Y [ ] N [ ]
If so, how much and how often?

○Estimate how much **water** you drink per day?
Source:

○How many servings of **fruit** and **vegetables** do you eat per day?
Organic or conventionally grown?

○Provide any other information that may be relevant, but hasn't been covered in regard to **diet:**

Stress

○How often do you take **time for yourself** and what does this look like to you?

○On a scale of 1 to 10, how **stressed** do you feel?
Briefly describe any stressful situations in you life right now:

○How many hours of **sleep** do you get each night?
Do you wake up feeling rested?

Radiations

○Do you use a **computer**? Y [ ] N [ ]
How long each day?

○Do you use a **cell phone** or tablet? Y [ ] N [ ]
How long each day?

○Are you exposed to **fluorescent lights** at work or home? Y [ ] N [ ]

○How often do you **travel by plane**?
When was the last time?

○Do you use a **microwave** oven? Y [ ] N [ ]
How often?

Chemicals

○Where did you **live** while growing up? City [ ] Rural [ ] Suburbs [ ] Other [ ]

○What is your **occupation:**

○What type of environment do you work in? Office [ ] Factory [ ] Other (describe) [ ]

○Are you exposed to **chemicals at work**? Y [ ] N [ ]
Name them:

○Any **tattoos**? Y [ ] N [ ]

○How many **cigarettes** do you smoke per day
For how many years?
If you quit, how long ago?

○How many **dental fillings** do you have?
How many have you had removed?
Date of most recent removal:

○How many **root canals** do you have?_____ Date of most recent:

○Do you have crowns or other metals? (braces, partials, retainers) Y [ ] N [ ]

○Do you use conventional or natural **deodorant**?

○Do you use **antacids**? Y [ ] N [ ]

○Are you, or have you ever, taken **birth control** pills? Y [ ] N [ ]
For how long? If you quit, how long ago?

○On a scale of 1 to 10, how intensely do you experience **PMS**?

○Have you ever had shots of **vaccinations** (including flu shot) Y [ ] N [ ]
Which ones? How long ago?

○What **drugs** have you taken **during your life,** recreational or prescribed (in addition to the ones you are currently taking, listed above):

○Have you ever been on **antibiotics**? Y [ ] N [ ]
How often?_____For what reasons?_____ Date of last Rx:_____

○Have you ever lived near any **farms** or large agricultural projects? Y [ ] N [ ]
What kind (dairy, vegetable, orchard, greenhouse)? When?
○Any **renovations** in your home within past 12 months? Y[ ] N [ ]

○List **cosmetics**/makeup/toiletries you use regularly. Specify if natural.

○List household **cleaning products** that you are exposed to. Specify if natural.

Which statement describes you the best:
[ ] I am fully ready for an improvement in my heath. I am ready for a detailed lifestyle, diet and supplement plan.
[ ] I am open to suggestions on how to see a change in my health. Just don't make it too complicated.
[ ] I am here strictly for information.
[ ] Other (describe)

○Is there anything that could get in the way of following a nutritional and lifestyle plan **in order to achieve results?**