# 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.

## Personal information:

| | |
|---|---|
| Name: | Phone Number: (H) (cell) |
| M [ ] F [ ] | E-mail address: |
| Age: | Address: |
| Referred By: | |
| Blood Type: A B AB O | Birth date: |
| | |

| | |
|---|---|
| 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[ ]<br>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 [ ]<br>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? | |
| 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 [ ]<br>All Purpose cleaners [ ]<br>Lawn or gardening chemicals [ ]<br>Other chemicals? |

## Client Statement

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purpose of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement has been signed voluntarily.

Date: _____ Signature: _____

Best time to contact you: _____

What is your preferred method of contact? _____

All information contained in these forms is used for consultations only and is kept strictly confidential

# Heilkunst Timeline
## Guide to Developing the Traumatic Timeline

As part of treatment, we ask that you complete a traumatic timeline.
The traumatic timeline involves listing, in chronological order, the emotional and physical traumas that you have experienced in your lifetime. These traumas are like shrapnel that has lodged themselves in your generative power or life energy (Qi, Prana etc.). The more traumas that we experience, the more our health deteriorates. The purpose of the traumatic timeline is to treat these traumas in chronological order, beginning with the most recent and working our way backwards to your birth. Treating these with homeopathic remedies will help you to regain your health, both emotionally and physically.

If you could list these events, with either the **date** or the **age** at which they occurred, and be sure to include any injuries, and/or any emotions that you experienced as a result, as well as any treatments or prescription medications that you may have taken due to the event. It will be impossible to remember every trauma so list what comes to mind for now and more can be added as you remember or the body shows presenting symptoms.

**Timeline Example**

- **2002**: fall requiring stitches, freezing
- **2000**: emotional – move to Ottawa – sadness, anxiety
- **1997**: vaccination for travel – Hep B, Yellow Fever (vaccine reaction, illness) etc.

The following types of events below are examples of what should be considered and listed as possible shocks or traumas in above example Traumatic Timeline.

**Physical examples:**

- **Pre-birth**: any drugs, alcohol, smoking or severe illnesses in mother (particularly of a viral nature); also consider any emotional shocks to mother during pregnancy or in mother/father at time of conception (see section on emotional traumas below); ultrasound or other invasive testing.
- **Birth**: Mother had difficult labour; forceps used; use of anaesthetics on mother; late breathing or other possible oxygen deprivation
- **Vaccinations**: Dates, if possible of first vaccination of each kind received (can ignore booster shots)
- **Accidents**: car accidents, falls, blows to head, concussions, broken bones, animal bites
- **Surgical interventions**: e.g., tonsils, appendix, adenoids, dental, abdominal (including Caesarean sections), circumcision, vasectomy, hysterectomy
- **Drug Use**: antibiotics, anti-depressants, recreational drugs etc.
- **Hormones**: birth control pill, hormone replacement therapy, IVF, etc.
- **Severe Infections**: e.g., Lyme disease, mononucleosis, Epstein-Barr, measles, chicken pox, mumps, TB, pneumonia, etc.
- **Electrical Shocks** (including medical treatment)

**Mental/Emotional examples:**

- Traumas involving loss, abandonment, grief, betrayal (e.g., death, loss of trust, relationship break-ups, loss of independence, job loss)
- Traumas involving great fear/anxiety, stress
- Traumas involving anger and indignation/humiliation (particularly where the emotion was suppressed/"swallowed"), guilt (mostly that someone tries to put on you)
- Feelings of envy or jealousy, or guilt that you put on yourself, self-blame, shame
- Traumas involving abuse, whether mental, emotional or sexual

NB: Some emotional traumas can involve a combination of emotions where you might feel fear, rage and sadness all at the same time. Be sure to list all emotions.