One Body Health & Wellness

Chantelle Hinze BScN, RN, ROHP, RNCP
Certified Live Cell Microscopist
NAET Practitioner
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Last Name	First Name	Date

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

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
List all allergies (food, drug, environmental etc.)	

Health History (Please check the boxes that are applicable. Add dates and comments as necessary.)

	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

	Dental Health Any? Amalgam? (silver fillings) _____ Root Canals?_____ Crowns?_____

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

Please list any past serious injuries, broken bones, surgeries, and procedures, including dates.

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?_____

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.)

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:

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One Body Health & Wellness Services	
Service	**Fee**
Initial Consultation- New Client-	**$275**
1 Hr Follow Up	**$150**
30 Min Follow Up	**$80**
Repeat Live Cell Microscopy	**$35 (plus appoint fee)**

Some Supplements may be recommended at an additional cost

**24 hrs cancellation is required or a 50 percent cancellation fee will be charged
All Monday Appointments must be cancelled before 5pm the previous Friday**

Name (Please Print): _____

Signature_____

Date:_____