CONFIDENTIAL CLIENT INFORMATION & QUESTIONNAIRE

Nu View Integrative Wellness
A 123 Scurfield Blvd. Wpg. MB
Contact: Maria De Stefano
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Email: maria@nuviewwellness.com

Important Preparatory Notes:

1. Please fast for 3-4 hours prior to the analysis. Eating prior to analysis will cause obscure results. Drinking water is fine and recommended.
2. Please shut off and insert cell phone in your assigned Faraday pouch upon entry to preserve integrity of blood sample.

1. Client Details

<table>
<tr><td colspan="3">Surname</td><td colspan="3">First Names</td><td>Title</td></tr>
<tr><td colspan="2">Date of Birth</td><td>Age</td><td colspan="4">I.D. Number</td></tr>
<tr><td colspan="3">Occupation</td><td colspan="2">Home Language</td><td colspan="2">Marital Status</td></tr>
<tr><td>Tel (H)</td><td colspan="2">Tel (B)</td><td>Cell</td><td colspan="3">E-Mail</td></tr>
<tr><td colspan="7">Home Address</td></tr>
<tr><td colspan="6"></td><td>Code</td></tr>
<tr><td colspan="7">Postal Address</td></tr>
<tr><td colspan="6"></td><td>Code</td></tr>
<tr><td colspan="7">Work Address</td></tr>
<tr><td colspan="7"></td></tr>
<tr><td colspan="6"></td><td>Code</td></tr>
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2. Person Responsible for Account

Names			Relationship
Address			
			Code
Tel (H)	Tel (B)	Cell	

3. Referred by / How did you hear about the practice?

Names	Tel

The purpose of this questionnaire is to assist you in identifying the sources and causes of your health challenges. As such, it focuses on questions relating to any symptoms you may be experiencing, lifestyle, treatments and conditions you have been diagnosed for. Answer all questions as best as you can to assist us in helping you on your path towards restored and better health.

4. Current Medication & Supplements

Medicine	Daily dosage	Date commenced
Medicine	Daily dosage	Date commenced
Medicine	Daily dosage	Date commenced
Medicine	Daily dosage	Date commenced
Medicine	Daily dosage	Date commenced
Medicine	Daily dosage	Date commenced
Supplement	Daily dosage	Date commenced
Supplement	Daily dosage	Date commenced
Supplement	Daily dosage	Date commenced
Supplement	Daily dosage	Date commenced
Supplement	Daily dosage	Date commenced
Supplement	Daily dosage	Date commenced

5. Main Complaint(s)

a)	When did it start?
How often do you experience the symptom?	
What relieves and aggravates the condition?	
b)	When did it start?
How often do you experience the symptom?	

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What relieves and aggravates the condition?	
c)	When did it start?
How often do you experience the symptom?	
What relieves and aggravates the condition?	
d)	When did it start?
How often do you experience the symptom?	
What relieves and aggravates the condition?	

6. Medical History

Diagnosis	Date diagnosed	Current □ / Previous □
Diagnosis	Date diagnosed	Current □ / Previous □
Diagnosis	Date diagnosed	Current □ / Previous □
Diagnosis	Date diagnosed	Current □ / Previous □
Diagnosis	Date diagnosed	Current □ / Previous □

7. Surgical History

Surgery	Date performed
Surgery	Date performed
Surgery	Date performed

8. Family Medical History

Father
Mother
Grandfather (paternal)
Grandmother (paternal)
Grandfather (maternal)
Grandmother (maternal)
Siblings
Children

9. General Health

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Energy levels (please rate): excellent □ good □ fair □ poor □	Lowest at ____________________ (time)
Sleep (please rate): excellent □ good □ fair □ poor □	No of hours:
Appetite (please rate): good □ poor □	No meals per day

10. Diet & Digestive System

(Please provide details on your average daily diet)	
Breakfast	Time
Mid-morning snack	Time
Lunch	Time
Midafternoon snack	Time
Dinner	Time

(Please specify how often the following foods are consumed per week)			
Alcohol	Bread	Ceylon tea	Cheese
Coffee	Fried foods	Fruit	Junk foods
Meat	Milk	Snack foods	Soft drinks
Sugar	Vegetables	Water	Wheat

Do you experience any of the following?		
Bloating	Nausea	Heartburn
Constipation	Diarrhea	Other

11. Additional Information

Do you experience any symptoms in the following areas?	
Menstrual Cycle	Details
Urinary Tract	Details
Sexual Function & Libido	Details
Dizziness	Details
Head	Details
Eyes	Details
Mouth	Details
Ears, Nose, Throat	Details

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Chest	Details
Joints / Limbs	Details
Skin	Details
Stress Levels	Details

12. Health Goals

Which health concerns are most important for you at the moment?

Consent and Indemnity

I ____ consent to have capillary blood drawn and my blood analyzed by the live blood analysis practitioner at this clinic.
I understand that the practitioner has received formal training in live & dry naturopathic blood analysis and that all necessary infection control measures are followed as stipulated by the Department of Health.
I understand that live blood analysis is not a medical diagnostic procedure, that it does not replace the advice of a medical practitioner, and that it is utilized as a nutritional assessment and education tool to assist with dietary and lifestyle recommendations.
I hereby indemnify the practitioner against any claim regarding my analysis, excluding those arising from malpractice.

Signature of client / guardian: _______________________________________
Date_______________________

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