Live Cell Analysis
Questionnaire

Please remember to fast (no food) for a *minimum of 4 hours* prior to your appointment.

You may drink water and are encouraged to drink at least four glasses before your appointment.

Remember to bring a snack to the appointment as you may want to eat.

Personal Information

1. Name: ______________________ Age: _______ M[ ] F[ ]
2. Address (including city, state, zip): ______________________
   ____
   ____
3. Phone number: (_____) ________-______________
4. Blood type: A B AB O
5. Where were you raised? ______________________
6. Occupation: ______________________
7. List paternal family diseases: ______________________
   ____
8. List maternal family diseases: ______________________
   ____
9. Do you have pets? ______________________
10. How often do you exercise? ______________
    What type of exercise do you do? ______________________
    ____
11. Do you experience digestive difficulties (bloating, constipation, gas, etc...)? __________
    Describe: ______________________
    ____
    ____

12. List any food or environmental allergies. ______________________

____

____

____

13. Describe your symptoms and health history as completely as possible.

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14. Have you ever been hospitalized for surgery? __________
If so, what kind and how many? ______________________________

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15. Describe and list all supplementation you are using. ______________

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____

16. List any medications you are taking and the reason you are taking it. ____

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____

Diet

17. Did/do you drink coffee? ________ How many years? _________
If you quit, when? __________

18. Did/do you drink black tea? ________ How many years? __________
If you quit, when? __________

19. Did/do you drink carbonated beverages? _________
How long? __________ Diet drinks? __________
If you quit, when? __________

20. Do you consume alcohol? __________ If so, how much and how often?

____

21. Do you eat large or regular amounts of chocolate? ___________

22. What is your water source? ___________________________

23. Do you eat organic fruits and vegetables? ___________________________

24. Write down everything you eat and drink over a typical three-day period. Include condiments, snacks, sweeteners, etc...

    Breakfast: ____
    ____
    Lunch: ____
    ____
    Dinner: ____
    ____
    Snacks: ____
    ____

    Breakfast: ____
    ____
    Lunch: ____
    ____
    Dinner: ____
    ____
    Snacks: ____
    ____

    Breakfast: ____
    ____
    Lunch: ____
    ____
    Dinner: ____
    ____
    Snacks: ____
    ____

25. Are you satisfied with your eating habits? ___________________________

Emotions

26. Is your occupation stressful? ___________________________________

27. How is your relationship with your coworkers? ______________________
____

28. Are your family relationships harmonious? ______________________

____

29. Are your friendships satisfying? ______________________________

30. Are there any stressful circumstances in your life right now? ________
Describe: ____

____

____

31. Are you traveling extensively? ______________________________

Chemicals

32. Are/were you a smoker? ________ How many years? _________
If you quit, when? __________

33. Do you have metal dental fillings? _______ How many? ________
Have you had any removed? ________ How many? _________
When? ___________

34. Do you have root canals? __________ How many? __________

35. Do you have crowns or other metals (braces, "flippers", partials, retainers. etc.) in your mouth? _________________
Describe: ____

____

36. Do or have you used aluminum cookware? __________

37. Do you use spray deodorants or antiperspirants? ___________
What kind? ____

38. Do you use antacids? __________

39. Are you now on or have you ever taken birth control pills? ___________
How many years? __________ What year did you begin? ___________

40. Are you now or have you ever been on estrogen replacement therapy?
____

41. Have you had inoculations? __________

42. What drugs have you taken during your life? (include prescription, over-the-counter, and recreational") ______________________________

____

____

43. Have you ever been on antibiotics? ______ When? __________
For how long? __________
For what reason? ____

44. Do you live near any farms or large agricultural projects? ________
If so, what kind (dairy, vegetable, orchard, etc...)? ________________
____
____

45. Do you live in preconstructed housing, such as a mobile or modular home? ________ How old is the home? __________

46. Has there been any kind of remodeling/construction in your home recently (sheet rock, paint, new carpets)? ______________________
____
____

47. What type of heating do you have in your home:
Wood burning stove? ________ Gas? ________ Electric? ________
Other? ______________________

48. What cosmetics do you use regularly? ______________________
____

Radiations

49. Do you live near any nuclear reactors or military bases? ________
If so, how many miles away is the facility? __________

50. Are there any high-tension lines or step-down transformers near your home or work? __________

51. Do you use a micro-wave oven? ________
Electric blanket? ___________ Water bed? _________

52. Do you have fluorescent lights? ______________________

53. Do you use a computer? __________ If so, how often? __________

54. Do you use a cell phone? __________
If so, how many hours per day? __________

55. List any other information you think might be relevant. __________
____
____
____
____
____

Jack Gagliardi, Homeopath
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PLEASE READ THE FOLLOWING CAREFULLY

*If under 18 years old, a parent or guardian must sign

I,____ the undersigned, understand that Jack Gagliardi is not a *medical doctor*, but instead a Homeopath. As such, I acknowledge that it is my right and responsibility, at any time throughout my treatment with Jack Gagliardi, to seek medical counsel and diagnosis, if so desired, from a medical doctor, for any present and/or future condition(s). I also reserve the right to terminate homeopathic treatment at any time if so inclined. I acknowledge that the state of my health is my own responsibility and that I am exercising my right to choose an alternative method of treatment, in homeopathy, that addresses my health in its entirety.

FEE SCHEDULE: (Payment Options: INTERAC, VISA, MasterCard, Cheque, Cash)

As homeopathy is not covered by existing government medical insurance plans, I agree to pay all fees incurred as presented in the current rate schedule below. (Rates are subject to change)

Live Blood Cell Analysis: $70

***Fees do not include HST**

***Some extended health care plans cover homeopathy**

Patient Name (Please Print): ____

Patient Signature: ______________________________________**Date:** ___________________