Visionary Health Medical Educational Clinic (VHMEC)
5359 Dundas St West Unit 108, Toronto, ON M9B1B1 647-478-9029 FAX: 647-557-3323
vhmec108@gmail.com info@vhmec.com www.vhmec.com

Intake - Live Blood Cell Analysis

Thank you for your interest in having an evaluation completed for you. The individual who is performing your evaluation has training in live blood cell Analysis. Therefore, they will not only be using information regarding physical conditions and nutrition, but they will also be considering the combined effects of lifestyle, environmental and emotional stressors. This evaluation process is intended to assist in the determination of causative factors, which may be related to traumas, which have been sustained from the combined effects of chemicals, diet, radiations and emotions. In order to assist in the completion of the evaluation process, please respond to the following questions in full.

First Name: _____ Last Name: _____Gender:_____

Date of Birth (MM/DD/YYYY): _____ Address _____

City:_____ Postal Code:_____ Phone: _____ Cell: _____

Emergency Contact. _____

Email: _____ Occupation: _____

How did you hear of Visionary Health? _____

Are you currently being treated by any other physician(s) or healthcare practitioners?

_____

Blood type: A B AB O Current Weight: _____ Height:_____

List one to five health concerns and main symptoms:
1.
2.
3.
4.
5.

Allergies:

Food: _____ Environment:_____

Bowel Health:

How often do you have a bowl movement? _____

Do you strain to have a bowel movement? _____

Do you have loose bowel movements? _____

Cravings:

Have you ever been diagnosed with an illness? Yes □ No □ If yes, Please explain: _____
Have you had any surgeries? Yes □ No □ If yes, Please explain:
_____ Missing organs?_____

How many hours on average do you sleep? Daily:_____
What time do you go to sleep? _____ Awaken: _____
Do you awaken feeling rested? Yes □ No □

Teeth:
Do you have any silver –mercury fillings? Yes □ No □

Family History:

Hereditary Diseases use F (Father), M (Mother), S (Siblings), G (Grandparents), O (Others)

___ Heart Disease	____ Diabetes	____Allergies
___ Hypertension	____ Arthritis	_____ Mental Illness
___ Intestinal Disease	____Osteoporosis	_____ other
___ Asthma	____ Ulcers	_____ Cancer

Have you been diagnosed with any of the Following:
Endocrine system (ex. Diabetes, hypoglycemic, menopause, thyroid) Yes □ No □
If yes, please explain: _____

Urinary System (ex. Kidney disease, urinary problems….) Yes □ No □
If yes, please explain: _____

Cardiovascular (high/low blood pressure, heart disease, varicose veins….) Yes □ No □
If yes, please explain: _____

Immune & Lymphatic (arthritis, chronic fatigue, HIV, allergies….) Yes □ No □
If yes, please explain: _____

Musculoskeletal (osteoporosis, fibromyalgia, back pain, scoliosis….) Yes □ No □
If yes, please explain: _____

Respiratory (asthma, emphysema….) Yes □ No □
If yes, please explain: _____

Nervous (vision, hearing, nerve pain, mental / emotional....) Yes □ No □
If yes, please explain: _____

Reproductive (PMS, endometriosis, prostate...) Yes □ No □
If yes, please explain: _____

Digestive (constipation, diarrhea, Crohn's, colitis, diverticulitis..) Yes □ No □
If yes, please explain: _____

Integumentary / Skin (psoriasis, eczema, warts...) Yes □ No □
If yes, please explain: _____

Female

Are you now on or have you ever taken birth control? Yes No
Are you Pregnant? Yes No
Are you pre-menopausal? Yes No
Are you experiencing and menopausal symptoms? Yes No If yes, explain;_____
Have you had a bone density test? Yes No If yes what was the result? _____
Occupation (any chemical, environmental exposure, stress)? Yes No
_____

Medication

What drugs have you taken ? (include prescription, over the-counter, and recreational")
List/Reasons_____
Do you use antacids? Yes No
List any food or Environmental Allergies_____
List any vitamins, minerals, herbal or homeopathic remedies you are currently taking and the amounts and dosages:_____

Dietary Habits

How many times do you eat? Main meals _____ Time of day_____
Snacks _____ Time of day_____
Do you eat with family?___ Alone__On the run__ Restaurant__ fast food___
How many servings of each do you typically eat in a day?

____Fruit: fresh ____ dried___ caned____ ____Vegetables: cooked_____raw____

____Whole Grains _____ Protein: Type _____ Dairy: type_____

What is your water source? _____

Give examples of your typical meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Are you Vegetarian?_____Vegan?_____
What are your favorite Foods?:_____
Craving:_____
How often do you eat them? _____
Do you experience any symptoms if meals are missed?
Explain_____
Do you experience any symptoms after meals?
Explain_____
Do you experience digestive difficulties (bloating, constipation, gas,
How is your concentration / focus? _____

Disclaimer: The information contained throughout this form is provided for reference and education only and is not intended to be a substitute for a physician's advice, diagnosis or treatment.

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INFORMED CONSENT- Nutrition & Live Blood Analysis

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and any recommended nutritional treatment or procedures- Live Blood Analysis to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after being informed of any benefits and risks involved. This document is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to treatment.

You are requested to sign document; informed consent documentation; permission to obtain sample (s) of blood droplets from you to view for the screening test and any other nutritional treatment protocol.

If you refuse any special procedure this will not affect your receiving other care or future treatments in the Clinic.

- I voluntarily give permission to Diana Jursa, CNP to obtain a sample(s) of blood droplets to view under the microscope, for the live blood cell analysis.
- I understand the information gained from this screening test- Blood Analysis, is of a nutritional nature and is not for a medical diagnosis, treatment or specific disease prevention.
- I understand that the procedure(s) that I am undergoing are not currently offered in medical laboratories.
- The professional conducting this screening test is a certified Microscopist and not a medical doctor.
- I understand that any suggested nutrition is not intended as a primary therapy for any disease or symptom.
- The results, if applicable, after the evaluation, I may be referred to a practitioner for further care.
- I understand that my verbal consent to a specific treatment and my willing participation in receiving these procedures after explanation of benefits and risks is sufficient to indicate my consent to receive treatment.
- I waive the option of signing consent to treat for each and every special procedure at each treatment date.
- I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time.
- I understand there may be complications and risks related to the recommended procedure(s) and that I may request additional information regarding complications and risks (side effects) and refuse any specific treatment at any time.
- I understand that there is payment for today's treatment, and subsequent follow-ups, at the time service accordingly to the fee schedule.
- A Missed Appointment Fee of $50 will be charged for any missed appointments or cancellations later than 9:30am of the business day prior to your appointment. (A business day is defined as Monday to Friday, excluding holidays)
- I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition.
- I understand that a record will be kept of the health services provided to me and will be kept confidential.
- I will give written/verbal consent and authorization for continued treatment/procedure(s) for any other practitioner.
- I understand that at the event there is a chance that media, audio or visual or published information could happen, all of which I am consenting to use all concerned forms of social media.
- I authorize the practitioner, clinic to make contact for educational events, promotions, incentives, newsletters, engaging and informing of any health benefits.
- I certify that I have read this form or have had it read to me, and that I understand its content and meaning. I have sufficient information to give this informed consent.

Patient Name (please print): _____

Patient Signature:_____ Date: _____