Personalized Nutrition Advanced Form

Please Use Blue Ink & Fill Out Form Completely (BOTH Sides)

Name : ______________________________ Birthdate : ________________ Age : _______
Address : ______________________________ City : ____________ State : _____ Zip: ____________
Phone : ____________________ Email : ____

Your BLOOD TYPE is REQUIRED BEFORE Your Zyto ELITE Scan! **YOUR Blood Type is?:** **O A B AB**

Where do/did you work? : ____

What do/did you do there? : ____

Who referred you to us? : ____

Allergies/Sensitivities : ____

Family Health History (Circle all that apply): Cancer? (Type): ____________ Heart Disease? Diabetes? Stroke?
Other: ____

What health challenges are you hoping to address as a result of adding **personalized** nutrition?: ________________
____

How long does it take you to **fall** asleep?: ____

Do you have trouble **staying** asleep for 7.5 or 9.0 hours?: ________________________________

How many times per night on average do you wake up after falling asleep?: ________________________

How much **total time** do you spend awake after falling asleep?: ________________________

How often do you wake feeling **refreshed**?: ________________________________

How often do you enjoy **deep** sleep?: ________________________________

Are you **Pregnant** or **Breastfeeding**? : Yes No

Is your **Blood Pressure** : Low Normal High Is your **Blood Sugar**: Low Normal High

Do you spend time in the **sun/use tanning booth**?: Y N Are you currently experiencing any **infections**?: Yes No

How many ounces of **water** do you drink per day?: ______ How many **meals** do you eat each day?: _______

Are you following **The Blood Type Diet**?: Yes No

Are there any particular **Foods/Beverages that you consume every day** (or almost every day)?: ________________

What **Type of Water** do you drink: City Well Bottled: ________________________________

What **Type of Filter** do you have for your drinking water?: ________________________________

Do you a filter on your **showerhead**?: Yes No

On average, how much **alcohol** do you drink **per day?** ___ oz. Beer White Wine Red Wine Liquor

On average, how much **caffeine** do you drink per day / week?: ________________________________
In which form (circle all)?: Coffee Tea Soda Pop Chocolate

Please List Any Surgeries: ____

Please List Any Head/Neck Injuries: ____

Please list ALL Nutritional Supplements you are currently taking: ________________________________
____
____
____

PLEASE CONTINUE ON REVERSE SIDE…

Please list ALL DRUGS (Prescription & OTC/Over-The-Counter)

	Name of DRUG	Purpose of Drug	How Long
1.	______________	______________	______________
2.	______________	______________	______________
3.	______________	______________	______________
4.	______________	______________	______________
5.	______________	______________	______________

Did your physician let you know that certain nutrients may be depleted by the drugs they prescribed? : Yes No

Have you ever been diagnosed with **Heart Failure**?: Yes No **Details**: ______________

Have you ever been diagnosed with **Kidney Disease**?: Yes No **Details**: ______________

Have you EVER taken an **Antibiotic**?: Yes No

How often do you take **Sodium Naproxsyn** (Aleve): ______________

How often do you take **Aspirin**: ______________

How often do you take **Ibuprofen** (Motrin): ______________

How often do you take **Acetaminophe**n (Tylenol): ______________

Have you ever had ANY **Vaccinations**?: Yes No

Have you ever had a **"Silver" Fillings** in your teeth?: Yes No

Have you ever had a **root canal**?: Yes No If so, which tooth (teeth)?: ______________

Have you ever had any type of **post** put into a tooth socket? : Yes No

Have you ever had **braces on your teeth** in your teeth?: Yes No

How often do you **Spray your house for Bugs**?: ______________

Do you live near a **farm**?: Yes No

What type of **Chemicals** do you use around your home or in your garden or yard? : ______________

Do you live in the flight path of an **Airport**?: Yes No

Do you live near ANY **Factories**?: Yes No

How much time do you spend driving, biking or walking in areas with **Motor Vehicle Traffic**?: ______________

How often do consume **Artificial Sweeteners** (Aspartame/NutraSweet; **Sucralose**/Splenda; Acelfame-K/Acelfame-Potassium/ Sunett/Sweet One): ______________

How often do you eat/drink food out of **Metal Cans**?: ______________

How often do you eat food heated in a **Microwave**?: ______________

Do you cook with aluminum or **Teflon Pans**?: Yes No

Do you use **Tobacco Product**s?: Yes No

Do you sleep on a mattress that has **Metal Coil Springs** inside?: Yes No

Do you sleep with a radio, clock, telephone, TV or computer near the **Head of your Bed**?: Yes No

Do you sit or sleep near the **Electric Meter** on the outside of your house?: Yes No

How often do you go **Barefoot** on the grass or sand?: ______________

By signing below, I certify that I understand that the **Nutrition SERVICES** (Consulting; Evaluations & Decision-Support Testing aka Zyto ELITE scans), **Nutrition PRODUCTS** (Vitamins, Minerals, Herbs, Amino Acids, Food Extracts, Glandulars, Food Concentrates, Enzymes, Bioidentical Hormones, Skin Care, Body Care, etc.) that are offered through McAnsh LIFE-ENERGY Institute or any of its employees are due and payable at the time of purchase or service and are NOT designed nor intended to diagnose, prevent, treat or cure ANY symptoms or disease. I further understand that all nutritional products purchased at McAnsh LIFE-ENERGY Institute, **once opened,** may **not** be returned for refund or credit due to **safety** considerations. **A 10% restocking fee will be applied to refunds on all unopened products purchased here** ***unless returned within the first 10 days after purchase.*** **There will no refunds of unopened products after 30 days.**

Client Signature: ______________ **Date Signed:** ______________

Doctor's Signature: ______________ **Date Signed:** ______________