Hair Test Information

Patient Information (adult):

Today's Date: ______________________________

Name: ______________________________

Gender: ______________________________

Weight: ______________________________

Address: ______________________________

Home Phone: ______________________________

Work Phone: ______________________________

Cell phone: ______________________________

Email: ______________________________

Birthdate: ______________________________

Birth location: ______________________________

What are your main Health Concerns?:

____

____

Family Illnesses, such as heart disease, cancer, TB, diabetes, arthritis, etc.:

____

____

Any recent medical tests you have had, and results:

____

How often do you exercise? What type(s) of exercise?:

____

How many hours of sleep do you get per night, on average?:

____

Supplements you are currently taking:

____

Medications you are currently taking:

____

<u>Diet Log:</u>
Please provide examples of a typical meal

Breakfast:

____

Morning Beverage(s):

____

Mid-morning Snack(s):

____

Lunch:

____

Mid-day Beverage(s):

____

Mid-afternoon Snack(s) :

____

Dinner:

____

Evening Beverage:

____

Evening Snack(s):

____

<u>Significant Stresses or Surgeries:</u>

Please list any significant stresses:

Please list any surgeries you have had:

Symptoms:

Please put an “X” next to any current symptoms:

	Joint pains
	Joint Stiffness
	Arthritis, Osteo
	Arthritis, Rheumatoid
	Muscle pain
	Muscle weakness
	Muscle cramps
	Bursitis
	Fractures
	Osteoporosis
	Gout
	Sweet cravings
	Sugar reactions
	Irritable before meals
	Can’t skip a meal
	Hypoglycemia
	Craves starches
	Craves fats
	Other food cravings
	Food allergies
	Excessive hunger
	No hunger
	Diabetes
	Rapid heart beat
	Skip heart beat
	Heart palpitations

	Heart attack
	Poor circulation
	Dizziness
	Low blood pressure
	High blood pressure
	Angina
	Arteriosclerosis
	High cholesterol
	High triglycerides
	Cough
	Bronchitis
	Asthma
	Post nasal drip
	Sinus congestion
	Allergies
	Emphysema
	Fatigue
	Hypothyroidism
	Low body temperature
	Cold in winter
	Dry skin / hair
	Tend to gain weight
	Tend to lose weight
	Hyperthyroidism
	Acne
	Eczema
	Fungal infections / Candida
	Psoriasis
	Hives
	Hair loss
	Slow wound healing
	Cataracts
	Meniere's disease
	Tooth decay
	Excessive plaque on teeth
	Gum disease

	Infections / Viruses
	Tumors / Cancer
	Multiple sclerosis
	Parkinson's disease
	Scleroderma
	Anger
	Anxiety
	Bipolar disorder
	Brain fog
	Confusion
	Depression
	Irritability
	Mind races
	Mood swings
	Obsessive / Compulsive
	Panic attacks
	Poor memory
	Schizophrenia
	Trouble sleeping
	Autism
	Attention deficit
	Hyperkinesia
	Dyslexia
	Seizures
	Learning Disability
	Mental retardation
	Delayed development
	Bladder infections
	Kidney infections
	Trouble urinating
	Frequent urination
	Painful urination
	Kidney stones
	Water retention
	Sinus headaches

	Tension headaches
	Migraine headaches
	Neuritis
	Eye diseases
	Constipation
	Diarrhea
	Intestinal gas
	Bloating
	Heartburn
	Ulcer
	Stomach pain
	Colitis
	Gall Stones
	Fissures
	Hemorrhoids
	Cirrhosis
	Diverticulitis
	Anemia
	Easy bruising
	Dental Amalgam (mercury filling)
	Drug addiction
	Alcoholism
	Smoking
	Women
	PMS
	Water retention
	Cramps
	No menstruation
	Heavy periods
	Light / Irregular periods
	Ovarian cysts
	Fibroid tumors
	Abnormal pap smear
	Menopause
	Fibrocystic breasts
	Breast tumors

	Yeast infections
	Hot flashes
	Men
	Prostate problems
	Impotence
	Infertility
	Other symptoms