## *GENERAL INFORMATION SHEET*

**Name________________________________________ Age____ Sex: M F Date__________**
**Address________________________________ City_____________ State____ Zip_________**
**Home Phone_________________________ Business Phone_____________________________**
**E-Mail Address___________________________________ Height________ Weight_________**
**Occupation____________________ How were you referred?___________________________**
**What are your main health concerns or conditions?__________________________________**

________________________________________________________________________________

**Please list any medications or food supplements you are currently taking:**

________________________________________________________________________________

________________________________________________________________________________

**Please list any recent medical tests results you have, such as blood tests:**

________________________________________________________________________________

**Please list illnesses in your family such as heart disease, cancer, TB, diabetes or arthritis.________________________________________________________________________**

**DIET: What are examples of typical breakfasts for you? Beverages**

____________________________________________________________|__________________

____________________________________________________________|__________________

**Mid-morning Snacks_________________________________________|__________________**

**What are typical lunches for you? Beverages**

____________________________________________________________|__________________

____________________________________________________________|__________________

**Mid-afternoon Snacks_______________________________________|__________________**

**What are typical dinners for you? Beverages**

____________________________________________________________|__________________

____________________________________________________________|__________________

**Evening Snacks____________________________________________|__________________**

**How often and what kind of exercise do you do?_____________________________________**

________________________________________________________________________________

**About how many hours of sleep do you get per day?__________________________________**

I understand that nutritional balancing is a means to reduce stress. It is not intended as diagnosis, treatment or prescription for any condition or disease. Jane Doe is a certified nutritional consultant with a degree in and work as an unlicensed nutrition consultant. I request and consent to having her set up a nutritional balancing program for me.

**Signed_____________________________________ Date____________**

Name________________________ ***SYMPTOMS SHEET***

**CIRCLE any conditions or symptoms that presently describe you.**
**PLACE A STAR next to the symptoms most important to you.**

Joint Pain
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 Meals
Hypoglycemia
Crave Starches
Fat Cravings
Other Food Cravings
Food Allergies
Excessive hunger
No hunger
Diabetes

Rapid Heart Rate
Skipped Heart Beats
Heart Palpitations
Heart Attack
Poor Circulation
Dizziness
Low or 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
Tend to Gain Weight
Hyperthyroidism

Acne
Eczema
Fungal Infections/Candida
Psoriasis
Hives
Hair Loss
Slow Wound Healing
Cataracts
Glaucoma
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
Hyperkinesis
Dyslexia
Seizures
Learning Disability
Mental Retardation
Delayed Development

Bladder Infections
Kidney Infections
Trouble Urinating
Frequent Urination
Painful Urination
Kidney Stones
Water Retentionn

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
Tend to Gain Weight
Tend to Lose Weight

Anemia
Easy Bruising

Drug Addiction
Alcoholism
Smoking

**WOMEN:**
Premenstrual Syndrome
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 or Comments:**

______________________________________________________________________

______________________________________________________________________

## *RETEST MINERAL ANALYSIS FORM*

**Name______________________________ Phone________________ Age ______ Sex: M F**

**Address ______________________________________________________________**

**Answer the questions below. Then circle your current symptoms on the *Symptoms Sheet*.**

*1. On a scale of 0-5, how closely have you been following your program? 0=not at all 5=perfectly*

*Lifestyle____ Diet____ Supplements____ Saunas____ Coffee Enemas____ Meditation____*

***2. Describe changes you have you noticed in your symptoms or condition over the past several months.***

***3. Do you have questions regarding your supplements, diet program, sauna therapy or coffee enemas?***

***4. Do you have questions in regard to any mental or emotional aspects, meditation or lifestyle challenges?***

***5. Are there other concerns you would like us to address when updating your healing program?***

The fee for a retest is US dollars. This includes your hair mineral analysis, a consultation on a compact disc with an updated healing program. It also includes brief follow up phone calls or emails. Payment can be made by personal check, money order or you may include credit card information, including the expiration date and the 3 or 4-digit security code on the back of the card.

**Mail this sheet, the symptom sheet (above this one), your hair sample and your payment to:**

Thank you for your confidence and patronage. You should receive your nutritional balancing program within about 3 weeks if mailed from within the United States.

* Nutritional balancing is a means to reduce stress and is not intended as diagnosis, treatment or prescription for any condition or disease. Jane Doe is certified in nutritional balancing science and works as an unlicensed nutrition consultant only.