GENERAL INFORMATION SHEET

Name:_____ Age: _____ Sex: M ☐ F ☐

Address:_____

City:_____State/Prov.:_____Postal Code:_____

Home Phone:_____Business Phone:_____

E-Mail Address:_____

Height:_____ Weight:_____ Pregnant: Y ☐ N ☐

Hair Color: _____ Type of Specimen: ☐ Head ☐ Pubic ☐ Other

Dyed?: Y N If yes, what brand or chemicals used: _____

Occupation:_____ How were you referred?_____

Would you be interested in nutritional balancing supplement program after reviewing hair analysis?

If yes, how many months of supplement would you like to order? ☐ 30 day ☐ 60 day ☐ 90 day

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:

_____

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

I understand that nutritional balancing is a means to reduce stress and balance body chemistry. It is not intended as diagnosis, treatment or prescription for any condition or disease.

Signed_____ Date:_____