Hair Testing for Sensitivities

Date Sample Taken / / **Name:** _____

Name of parent/guardian of child: *(if under 18years of age)*

Date of birth: / / **Sex: F/M** **Referred by:** _____

Address: _____

City: _____ **Postcode:** _____

Preferred contact/s: (Work) _____(Home) _____(Mobile) _____

E-mail address: _____

Please tick Symptoms

[ ] Sinus/Hay fever	[ ] Rashes/Itchy skin/Eczema	[ ] Heartburn/reflux	[ ] Stomach/abdominal pain
[ ] Asthma	[ ] Arthritis	[ ] Constipation	[ ] Fatigue/Tired
[ ] PMT	[ ] Psoriasis	[ ] Diarrhoea	[ ] Behaviour issues
[ ] Headache	[ ] Excess Mucous	[ ] Bloating	[ ] Sleep disturbances
[ ] Migraine	[ ] Thrush	[ ] Flatulence	[ ] Aching joints
[ ] Acne	[ ] Earache/infection	[ ] Hives	[ ] Restless legs
[ ] Endometriosis	[ ] Lower back pain	[ ] Tonsillitis	[ ] Lowered immunity

Other symptoms:

Baby food (if current) [ ] Breast [ ] Bottle [ ] Solids [ ] Combination

Currant Medications/Supplements taking:

_____

Known Sensitivies/Allergies:

_____

List of foods avoided and for how long:

_____

Additional products to test: (refer to back page of 'products listed' list) please specify which particular product you which to test e.g Persil Sensitive

_____

_____

For returning results, please send to: The Herbal Shop & Clinic, 2 Lorne Street, Melville, Hamilton 3206
Hair test cost: **$135.00** **(NZ)** **Method of payment:** *please tick one*

- **Internet banking A/C number BNZ 02 0312 0136855 00** *(please use your name as a reference)*
- **In Store**
- **Credit Card via phone**

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For Office Use Only - Please tick boxes and date when procedures are completed

Client paid -	……/……./…..…..
Copy taken -	……/……./…..…..
Hair Test Results received - - - - - - - - - - - - - - - - - -	……/……./…..…..
Hair Test Results sent/picked up/e-mailed - - - - - - - - - - -	……/……./…..…..
Results put in folder -	……/……./…..…..
Follow-up Booked -	……/……./……