Intolerance Hair Test Request Form

Today's Date: _____/_____/_____ Test Type: ☐ 1st ☐ Re-test ☐ Mother & Baby

Name: _____ Date of Birth: _____/_____/_____

Parents name if child under 18 years: _____

Preferred method for receiving results: E-mail: ☐ Mail: ☐ *Please print clearly…*

Address: _____

Phone: _____ Occupation: _____

Symptoms List:

☐ Headaches/Migraines	☐ Frequent colds/flu	☐ Miscarriages
☐ Tonsillitis/Sore throat	☐ Asthma/Cough	☐ Fertility challenges
☐ Arthritis like pain	☐ Eczema/Psoriasis/Dry skin	☐ Foggy Brain
☐ Lower back pain	☐ Ear infections	☐ Reflux/Indigestion
☐ PCOS	☐ Endometriosis	☐ Diabetes
☐ Flatulence/Belching	☐ Low energy	☐ Auto-Immune issues
☐ Thrush	☐ Constipation	☐ Diarrhea
☐ UTI's	☐ Sleeping issues	☐ Gout
☐ Other symptoms/conditions:		

Medications or Supplements currently taken:

_____

_____

Known allergies or intolerances:

_____

_____

Any foods being avoided & for approximately for how long:

_____

_____

Any extra foods/substances to be tested - please refer to second hair test list:

_____

_____

_____

Wendy Eyre – Medical Herbalist P: 0274708240 E: medicalherbalistnz@gmail.com

For Office Use only:

□ Hair test paid	/ /
□ Consultation pre-paid	/ /
□ Test sample sent to Julie	/ /
□ Julie payed	/ /
□ Results returned to me	/ /
□ Details sent to client	/ /

Notes:

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