HAIRS TO YOUR HEALTH, LLC

RE-TEST MINERAL ANALYSIS STATUS FORM

Name_____ Phone_____ Date_____

Address_____

Sex: M F Age _____ Height_____ Weight_____ Hair Color_____

Please answer the questions below.

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

Diet_____ Supplements_____ Water_____ Lifestyle_____ Rest_____ Sauna/Heat Lamp_____

Spinal Twist_____ Foot Rubs_____ Coffee Enemas_____ Roy Meditation_____ Skin Brushing_____

2. What is your current diet?

Meal	Food	Beverage
Breakfast		
Lunch		
Dinner		

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

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

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

_____

_____

_____

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

_____

_____

_____

Please also complete the attached Symptoms Form.

I understand that Nutritional Balancing is not intended as diagnosis, prescription, treatment or cure for any disease or health condition, mental or physical, real or imaginary. It is also not intended as a substitute for regular medical care and that I am encouraged to seek a second opinion from a medical provider and that any nutritional balancing information offered is considered as general information only.

I understand that under no circumstances should any medication be discontinued without first consulting the prescribing medical provider. I will refrain from combining this program with other dietary, nutritional or herbal regimens as it may impair this program's effectiveness. I also confirm by signing this document that I have not been diagnosed with any form of cancer or am in remission from any form of cancer.

I understand that the Nutritional Balancing information offered is also not intended as a substitute for regular medical care and that I am encouraged to see my medical provider for diagnosis and treatment of any medical concerns that I may have, and before implementing any diet, supplement, exercise or other lifestyle change. I also understand that Nutritional Balancing is to be used at my own risk.

NAME: _____

ADDRESS: _____

SIGNED: _____

DATE: _____

HAIRS TO YOUR HEALTH, LLC

RE-TEST SYMPTOMS SHEET

Name_____ ***Date***_____

Please CIRCLE any conditions or symptoms that you are presently experiencing and place a STAR next to those symptoms most important to you.

Joint Pain	Joint Stiffness	Arthritis	Osteoarthritis	Muscle Pain
Rheumatoid Arthritis	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
Low Blood Sugar			

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	

Acne	Eczema	Fungal Infections/Candida	Psoriasis
Hives	Hair Loss	Slow Wound Healing	Cataracts
Nail Issues	Glaucoma	Eye Diseases	Meniere's disease
Tooth Decay	Gum Disease	Excessive Teeth Plaque	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

Kidney Stones	Water Retention	Sinus Headaches	Tension Headaches
Migraine Headaches	Neuritis	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	Abuse

Fatigue	Hypothyroidism	Low Body Temperature	Cold in Winter
Hyperthyroidism	Hair thinning	Hair falling out	Dry Skin
Oily Skin			
Bladder Infections	Kidney Infections	Trouble Urinating	Frequent Urination
Painful Urination	Kidney Stones	Water Retention	

WOMEN:

PMS	Water Retention	Cramps	No Menstruation
Heavy periods	Light Periods	Irregular Periods	Menopause
Ovarian Cysts	Fibroid Tumors	Abnormal Pap Smear	Fibrocystic Breasts
Breast Tumors	Yeast Infections	Hot Flashes	Infertility
Libido Issues	Rape	Pregnancy	

MEN:

Prostate Problems	Impotence	Infertility

Other Symptoms or Comments You Would Like to Add:

_____
_____
_____
_____