Christine-Jane

Naturopath & Medical Herbalist

BHSc.(Comp.Med), Adv.Nat, Adv.Herb
Diploma Fertility & Reproductive Health, Massage Therapist

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Date sample taken_____ Referred By:_____

Client Name:_____

Email:_____

Contact phone number:_____ Date of Birth:_____

Please tick symptoms

{ } Sinus/hayfever	{ } Rashes/itchy skin/Eczema	{ } heartburn/reflux	{ } low immunity
{ } Asthma	{ } psoriasis	{ } constipation	{ } stomach/abdom pain
{ } PMT	{ } arthritis	{ } Diarrhoea	{ } fatigue/Flat
{ } headache/migraines	{ } excess mucus	{ } Bloating	{ } behaviour issues
{ } anxiety/depression	{ } Thrush	{ } flatulence	{ } sleep disturbances
{ } Acne/boils	{ } earache/infection	{ } Hives	{ } aching joints
{ } endometriosis	{ } lower back pain	{ } tonsillitis	{ } restless legs

Other symptoms:_____

_____

_____

Baby Food (if current) { } breast { } bottle/formula { } solids { } other _____

Medications and supplements:_____

_____

_____

Known allergies/intolerances:_____

_____

_____

List of foods avoided and for how long:_____

_____

Additional Products to test:_____

_____

(please make note that if you have been avoiding a certain food or substance, it may not show up on your results, this does not mean you should re-introduce, it just means that you are not showing a response due to avoidance in the diet.)