Nutritional Balancing Program

RETEST FORM

GENERAL INFORMATION

NAME____

STREET______________________________ CITY_______________ STATE_______ ZIP___

PHONE (H OR CELL)_____________________ EMAIL ADDRESS______________________

AGE____________ HAIR COLOR __________ HEIGHT ________ WEIGHT _________ SEX: M F

HEALTH PROGRESS

Answer the questions below. Then circle your current symptoms on the symptoms sheet on the next page. Use page 3 of these forms for any additional comments or if you don't have enough room here.

1. On a scale of 0-5, how closely have you been following your program? 0=Not at All / 5=Perfectly

Lifestyle____ Diet____ Supplements____ Saunas____ Coffee Enemas____ Meditation____

Water____ Sleep____ Spinal Twist____ Foot Rubs____

2. What is your current diet (honesty is key here so we can best help you and determine what you need)

WHAT ARE EXAMPLES OF TYPICAL BREAKFASTS FOR YOU? FOOD | BEVERAGES

____ | ______________

WHAT ARE EXAMPLES OF TYPICAL LUNCHES FOR YOU? FOOD | BEVERAGES

____ | ______________

WHAT ARE EXAMPLES OF TYPICAL DINNERS FOR YOU? FOOD | BEVERAGES

____ | ______________

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

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

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

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

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SYMPTOMS SHEET

CIRCLE any conditions or symptoms that presently describe you
PLACE A STAR next to the symptoms most important to you

Joint pain
Joint stiffness
Arthritis, osteo
Arthritis, rheumatoid
Muscle pain
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
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
Fatigue
Hypothyroidism
Low body temperature
Cold in winter/dry skin
Hyperthyroidism

Acne
Eczema
Fungal infections/candida
Psoriasis
Hives
Hair loss
Slow wound healing
Cataracts
Glaucoma
Meniere's disease
Tooth decay
Excessive plaque on teeth
Gum disease
Infections/viruses
Tumors/cancer
Multiple sclerosis
Parkinson's disease
Scleroderma
Fear
Anger
Anxiety
Bipolar disorder
Brain fog
Confusion
Depression
Irritability
Mind races
Mood swings
Obsessive/compulsive
Panic attacks
Poor memory
Schizophrenia
Trouble sleeping
Suicidal thoughts
Autism
Attention deficit
Hyperkinesis
Dyslexia
Seizures
Learning disability
Mental retardation
Delayed development
Bladder infections
Kidney infections
Trouble urinating
Frequent urination
Painful urination
Kidney stones
Water retention

Sinus headaches
Tension headaches
Migraine headaches
Neuritis
Eye diseases
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
Dental amalgams
Drug addiction
Alcoholism
Smoking

WOMEN:

Premenstrual syndrome
Cramps
No menstruation
Heavy periods
Light/irregular periods
Ovarian cysts
Fibroid tumors
Abnormal pap smear
Menopause
Fibrocystic breasts
Breast tumors
Yeast infections
Hot flashes
Infertility

MEN:

Prostate problems
Impotence
Infertility

OTHER QUESTIONS OR COMMENTS

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FEE SCHEDULE & PAYMENT INFORMATION

REPEAT HAIR MINERAL ANALYSIS ALL AGES: $150
ADDITIONAL PHONE/EMAIL CONSULTATION: $60 PER HOUR

THERE ARE FOUR WAYS TO MAKE YOUR PAYMENT – circle the one you choose:
1. I WOULD LIKE TO RECEIVE AN EMAIL INVOICE WHICH I CAN PAY SECURELY ONLINE
2. I AM SENDING YOU MY PAYMENT THROUGH PAYPAL TO invoices@healingaia.com
3. I AM INCLUDING A CHECK PAYABLE TO HEALINGAIA (adds 3 to 5 business days for processing)
4. I AM ENTERING MY CREDIT CARD DETAILS BELOW

FIRST NAME:________________________________ LAST NAME:____

CARD TYPE: VISA MASTER CARD CARD NUMBER: _ _ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _

EXP DATE: MONTH _ _ YEAR _ _ 3 DIGIT SECURITY CODE: _ _ _ AMOUNT AUTHORIZED: $_____

BILLING ADDRESS: ____

COUNTRY:___________________ EMAIL:____________________________ HOME PHONE: ____________________

AUTHORIZED SIGNATURE:____ DATE:_____________________

Mail all 3 sheets with your hair sample and payment to:
Whole System Healing
P.O. BOX 1188
OJAI, CA 93024
USA