 **Dietx Testing Questionnaire**

Please fill out and answer the questionnaire below as it will help the

intolerance therapist to assess your health condition prior to your test.

Name: ………………………………………………… D.O.B: …………………………………………………

Address: ……………………………………………………………………………………………………

………………………………………………………

Email:………………………………………………… Occupation:………………………………………..

Phone number:……………………………………

What is the reason for coming to have the session?

…………………………………………………………………………………………………………………………………………

Please indicate whether you suffer from any of the symptoms listed below.

Please do so by giving a number from 0-5, 0= Never, 1=Rarely, and 5 being a lot.

Headaches…… Chronic cough……

Palpitations……

Tiredness…… Asthma……

Muscle pain……

Hyperactive…… Hay fever……

Joint pain……

Mood swings…… Catarrh……

Sleeplessness……

Acne…… Constipation……

Cystitis ……

Mouth ulcers…… Diarrhoea……

Vaginal discharge……

Water retention…… Bloatedness……

Rashes……

Gut spasms…… Flatulence……

Eczema……

Do you have any known foods that cause you a problem? ……………………………………

Are you on any medication, vitamins, minerals or herbs? If so please list.

……………………………………………………………………………………………………………………………………………………

Have you consulted a Dr about your condition? ……………………………………



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I understand that the test I am about to undertake is not a medical test, nor does it form part of any medical diagnosis. It is in fact a simple test used by an intolerance therapist to try and pin point potential foods that may be causing me a health problem. I understand that it has an accuracy of between 75 - 80% and in order to fully complete this program I must eliminate the suggested foods to see if they are in fact causing a problem . I agree to undertake any advice as a result of this test of my own free will.

Signed: …………………………... Date: …………………………