HAIR ANALYSIS – APPLICATION

Personal Details (Strictly Confidential)

Name:	M/F (please circle) Tel:	
Address:	Mobile:	
	Email:	
Postcode:	Age:	Height:
	Occupation:	
First Test Retest (please tick)		
How did you find us?		
Practice Details:		
Postcode:	Tel:	
Please indicate where the test results should be sent to: Patient		Practice
Medication (prescription only)		
Supplements		
Medical Conditions		
		Do you smoke?

Symptoms

Please list the top five symptoms which you are currently suffering from, in order of seriousness. You can write a full medical history on the reverse of this form if you wish.	
1	
2	
3	
4	
5	

Hair

Place a minimum of three hairs - anywhere on the body will do - in the space below making sure that the root of the hair is attached. Please DO NOT TAPE OVER THE ROOT.

Medical History – please enclose extra pages if this space is not enough

Credit Card Payment

PAYMENT DETAILS:

VISA □ **SWITCH** □ **OTHER** □

CARD NO: __ __ __ __ / __ __ __ __ / __ __ __ __ / __ __ __ __

START DATE: __ __ /__ __ EXPIRY DATE: __ __ / __ __ SECURITY CODE: __ __ __ ISSUE NO: __

(LAST 3 DIGITS ON BACK OF CARD ABOVE SIGNATURE)