

RETEST MINERAL ANALYSIS FORM*

Surname:	Name:	
Date of Birth (Day,Month,Year):	Weight (kg):	Height (cm):
City:	Country:	
Phone:	E mail:	

List any medications you currently take (name, dosage, frequency):

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 ____ Sleep ____ Saunas or heat lamp ____
Pushing Down Exercise ____ Reflexology ____ Coffee Enemas ____ Spinal twist ____

2. What is your typical current diet?

Breakfast:

Beverages:

Lunch:

Beverages:

Dinner:

Beverages:

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

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

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

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

Thank you. You should receive your program within about 3 weeks.

** I understand that nutritional balancing is a means to reduce stress and balance body chemistry. It is not intended as diagnosis, treatment or prescription for any condition or disease.*

Signed: _____ Date: _____

SYMPTOMS

Circle any conditions or symptoms that you have. Place a Star next to the symptoms most important to you.

Joint pain	Hyperthyroidism	Sinus headaches
Joint Stiffness	Acne	Tension headaches
Arthritis, Osteo	Eczema	Migraine headaches
Arthritis, Rheumatoid	Fungal Infections/Candida	Neuritis
Muscle pain	Psoriasis	Eye diseases
Muscle weakness	Hives	Constipation
Muscle cramps	Hair loss	Diarrhea
Bursitis	Slow wound healing	Intestinal gas
Fractures	Cataracts	Bloating
Osteoporosis	Glaucoma	Heartburn
Gout	Meniere's disease	Ulcer
	Tooth decay	Stomach pain
Sweet cravings	Excessive plaque on teeth	Colitis
Sugar reactions	Gum disease	Gall stones
Irritable before meals		Fissures
Can't skip meals	Infections/ Viruses	Hemorrhoids
Hypoglycemia	Tumors/Cancer	Cirrhosis
Crave starches	Multiple sclerosis	Diverticulitis
Fat cravings	Parkinson's disease	Tend to gain weight
Other food cravings	Scleroderma	Tend to lose weight
Food allergies	Fear	
Excessive hunger	Anger	Anemia
Diabetes	Anxiety	Easy bruising
	Bipolar disorder	
Rapid heart rate	Brain fog	Dental amalgams
Skipped heart beats	Confusion	Drug addiction
Heart palpitations	Depression	Alcoholism
Heart attack	Irritability	Smoking
Poor circulation	Mind races	
Dizziness	Mood swings	WOMEN:
Low Blood pressure	Obsessive/Compulsive	Premenstrual syndrome
High Blood pressure	Panic attacks	Water retention
Angina	Schizophrenia	Cramps
Arteriosclerosis	Trouble sleeping	No menstruation
High cholesterol	Suicidal Thoughts	Heavy periods
High triglycerides	Autism	Light / Irregular periods
	Attention Deficit	Ovarian cysts
Cough	Hyperkinesis	Fibroid tumors
Bronchitis	Dyslexia	Abnormal Pap Smear
Asthma	Seizures	Menopause
Post-nasal drip	Learning Disability	Fibrocystic breasts
Sinus congestion	Mental Retardation	Breast tumors
Allergies	Delayed Development	Yeast Infections
Emphysema		Hot flashes
	Bladder infections	
Fatigue	Kidney infections	MEN:
Hypothyroidism	Trouble urinating	Prostate problems
Low body temperature	Frequent urination	Impotence
Cold in winter / Dry skin	Painful urination	Infertility
Tend to gain weight	Kidney stones	
	Water retention	

Eye conditions _____

Other symptoms or comments: