

CLIENT INFORMATION

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Email address: _____
Birthday: _____ Weight: _____ Height: _____ Gender: M F
Female patients: Are you pregnant? Yes / No Are you breastfeeding? Yes / No

Major Concerns: _____

Prescription Medications: _____

Supplements currently taking: (Vitamins/Herbs) _____

Family history of illness or disease: _____

PAYMENT INFORMATION

Cost of test is \$125 for adults, \$75 for CHILDREN UNDER THE AGE OF 16.

Re-Tests are free with the purchase of all recommended supplements from prior visit.

How did you hear about us? _____

**Please make sure to read the
Disclaimer and Sign as well.**