Client Questionnaire

Name (Please Print)

_____

Address

_____

City_____State_____

Post Code _____ Telephone # _____

E-mail

_____

Gender _____ Date of Birth _____ Referred By _____

Report Type: **Optimise Naturally** **Sport and fitness** **Elite sport and fitness**

I ordered this test for: (please circle below)

Disease prevention Rehabilitation Sport fitness support Supplementation

Is this your first or second test? _____

I am planning pregnancy I am pregnant_____ months I am breast feeding

Mark any symptoms:

Frequent feeling of fatigue Concentration disorders Memory disorders waking up at night

Constant or frequent feeling of "anxiety" Frequent headaches Vertigoes

Lip sores Tinnitus Cramps Dry skin Greasy skin frequent hungry feeling

Frequent thirsty feeling other:_____

Dietary Style (please circle)

I am on low carbohydrate diet I am on vegetarian diet I am on protein diet

I am not on any diet I eat a lot of fruit and drink fruit juices I eat a lot of meat and fats

I eat dairy products I eat fish I eat sweets I crave? _____

Response to stress:

I am often aggressive everything bothers me I am oversensitive I often have fears

I am susceptible to depression

Life style:

I work more than 8 hours per day I have an easy job I do manual labour I smoke cigarettes

I often sit up till late at night I often drink alcohol I live under continuous stress

Nutrition:

I often feel like having: sweet meals sour meals Spicy meals Salty meals

I drink coffee regularly I often drink tea I drink _____ water in a day

Exposure to adverse factors at work:

Chemicals Temperature Electromagnetic field (computers etc.) Noise

Other_____

Current medical conditions

_____

Current Prescribed medicines

_____

Current Supplementation

_____

Informed Consent Statement: I hereby attest and agree to the following:

I fully understand that Lyn Collett is a natural health advisor who aids in improving health through information.

I fully understand that the above person is not a licensed physician and cannot diagnose, prescribe drugs, or recommend treatment for specific conditions.

I understand that all analyses performed by above person are designed to allow me to make informed decisions regarding my health. I further understand that said analyses cannot diagnose specific disease conditions I may have and will not replace diagnostic services offered by licensed health care providers.

I understand that above person neither claims nor implies that any services they provide, whether in person, mail, telephone, or e-mail, will cure, treat, prevent or mitigate any disease conditions: but are provided solely for purpose of information supported by actual research.

I certify that above has not suggested any medical care be discontinued. I understand that the decisions I make regarding my health and the health care of those under my guardianship are my responsibility and certify that I will not hold above person responsible for the consequences of my decisions.

I have read & understand the forgoing and agree to the terms & conditions set therein. I have been given a copy of this "INFORMED CONCENT" for my records.

By my signature, I hereby consent to the aforementioned.

Signature_____Date_____

Please Print
Name_____

Direct deposit Information:

Westpac Bank

Lynette M Collett

BSB: 734 230

Account: 633818

Please use your name as the reference.

Deposit must be made before hair sample sent to avoid any extra time in receiving and using the sample.

Please send sample via express post