

Christine-Jane

Naturopath & Medical Herbalist
BHSc.(Comp.Med), Adv.Nat, Adv.Herb
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Massage Therapist



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Date sample taken _____ Referred By: _____

Client Name: _____

Email: _____

Contact phone number: _____ Date of Birth: _____

Please tick symptoms

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Sinus/hayfever | <input type="checkbox"/> Rashes/itchy skin/Eczema | <input type="checkbox"/> heartburn/reflux | <input type="checkbox"/> low immunity |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> psoriasis | <input type="checkbox"/> constipation | <input type="checkbox"/> stomach/abdom pain |
| <input type="checkbox"/> PMT | <input type="checkbox"/> arthritis | <input type="checkbox"/> Diarrhoea | <input type="checkbox"/> fatigue/Flat |
| <input type="checkbox"/> headache/migraines | <input type="checkbox"/> excess mucus | <input type="checkbox"/> Bloating | <input type="checkbox"/> behaviour issues |
| <input type="checkbox"/> anxiety/depression | <input type="checkbox"/> Thrush | <input type="checkbox"/> flatulence | <input type="checkbox"/> sleep disturbances |
| <input type="checkbox"/> Acne/boils | <input type="checkbox"/> earache/infection | <input type="checkbox"/> Hives | <input type="checkbox"/> aching joints |
| <input type="checkbox"/> endometriosis | <input type="checkbox"/> lower back pain | <input type="checkbox"/> tonsillitis | <input type="checkbox"/> restless legs |

Other symptoms: _____

Baby Food (if current) breast bottle/formula solids other _____

Medications and supplements: _____

Known allergies/intolerances: _____

List of foods avoided and for how long: _____

Additional Products to test: _____

(please make note that if you have been avoiding a certain food or substance, it may not show up on your results, this does not mean you should re-introduce, it just means that you are not showing a response due to avoidance in the diet.)

“Showing people there are many ways in which you can improve your health and well-being”

