MINERAL DEFICIENCY ANALYSIS FORM

CONTACT DETAILS :

Surname :	Given Name :		Title :
Street Address :			
Suburb :	State :	Postcode :	DOB:
Phone (H) :	Phone (B) :		
Mobile :	Email:		

If specified by your practitioner, please provide two current photographs -
1: Full photo of face, front on with eyes closed 2: Full photo of face turned slightly away to see the corner of the eye

PLEASE NOTE : When you come for your appointment, please do not wear any makeup or tinted moisturiser as Facial Diagnostics is used to confirm your mineral deficiencies.

What is the main issue you would like addressed?

Please indicate in the ☐ boxes below current and past symptoms by inserting either C (current) or P (past)

You can write any additional notes relating to these symptoms in the space provided on page 5

	Loose Ligaments	1		Hay Fever	2 3 8 6 11		Bowel Motions Putrid	5
	Flat Feet	1		Sleeplessness	2 7 5		Bite Nails and Spit Out	5
	Bone Spurs	1 11		Acne	2 9 4 12		Hair loss	5 11
	Hernia	1		Thyroid Disorders	2 7		Psoriasis	6 12
	Weak/Thin Skin	1 11		Pancreatitis	2 3 10		Flu	6 10 3 4
	Hard or Swollen Lymph	1 4 9 11		Fidgety, Can't Keep Still	2 11		Dry Peeling Scales on Skin	6 8
	Warts	1 11		Loss of Appetite	2 4		Slimy Secretions of Mucous	6
	Haemorrhoids	1 11 4		Muscles Ache	2 7 9		Chest Constriction	6
	Shin Splints	1 2 11 7		Arthritis	2 9 11		Dandruff	6
	Bone or Teeth Decay	1 2 7 9		Easily Bruise	3		Ear Infections with Discharge	6
	Corns or Calluses	1 11		Weak Immune System	3 4		Chest Infections	6
	Bite Nails and Eat Them	1 2		Hot Flushes	3 2		Catarrh (thick yellow mucous)	6 3 4 11
	Varicose or Spider Veins	1 3 11		Nasal Inflammation	3 6		Rattling in Chest no Cough	6
	Neuralgia	1 7 12		Tonsillitis	3		Liver Problems or Infection	6 10
	Prolapsed Organs	1		Ear Infections	3 11		Diabetes Type 1	7 2
	Flabby Stomach / Breast / Arms	1		Asthma	3 5		Diabetes Type 2	7 2
	Bone Fracture	1 2 11		Cold Sores	3 10		Muscle/Nerve/Face Twitching	7
	Scoliosis	1		Fungal Skin Infections	3 10		Stomach Cramps	7 10
	Skinny Children, Pale Skin	1 3 11		Tendonitis	3 4 11		High or Low Blood Pressure	7
	Bladder Urgency	1 2 8 9 11		Bronchitis	3 4 6		High or Low Cholesterol	7
	Cracked Heels	1 2 11		Glandular Fever	3 4 5		Excessive flatulence (no smell)	7
	Blood Thin	2		Tennis Elbow	3 4 11		Heart Palpitations	7 5 6
	Nose Bleeds	2		RSI	3 4 11		Excessive Dryness of Skin	8 11
	Anaemia	2 3 8		A Cold more than 1 per Year	3 4		Oedema (swellings of the skin)	8 10
	White Sweat Marks on Clothes	2 9		Diarrhea	3 10		Irritable / Snaps Easily	8
	Osteoporosis	2 9 11		Sunburn Easily	3		Itchy Skin	8 11
	Calf Cramps	2 7		Sinusitis	3 4 6		Dry Eyes	8
	Eczema	2		Conjunctivitis	4 6 9		Runny Nose (watery)	8
	Poor Concentration/Memory	2 11 5		Blood Thick	4		Loss of Taste or Smell	8
	Growing Pains in Legs	2 7		Catarrh (thick white/grey mucous)	4		Frequent Urination after Water	8
	Cold Hands or Feet	2 8 1		Chew Skin around Fingernails	5 1		Mucous Covered Bowel Motions	8
	Pale Coloured Bowel Motions	2 4		Drooping Eyelids	5		Joints Crack with Movement	8
	Digestive Complaints	2 7 8 9		Headaches / Migraines	5 8		Cries Easily	8
	Degenerations of Joints	2 9 11		Depression / Anxiety / Sorrow	5 6 8 10		Bloating After Meals	8 7

Please indicate in the ☐ boxes below current and past symptoms by inserting either C (current) or P (past)

You can write any additional notes relating to these symptoms in the space provided on page 5

	Tired on Waking	8		Tiredness After Meal	10		Allergies (more info please)
	Watery eyes	8		Discomfort Lying on LH Side	10		Candida
	Bladder/Kidney/Gall Stones	9 11		Jaundice (skin is yellow)	10		Stroke/Thrombosis/Aneurysm
	Acid Reflux	9		Spare Tyre at Waist (fluidy)	10		Heart Disease
	Rash Honey Coloured Matter	9		Stinky, Sweaty Feet	11		Chronic Fatigue
	Blisters Honey Coloured Matter	9		Chaotic Personality	11		Fibromyalgia
	Intestinal Worms	9 10		Procrastinate	11		Ross River Virus
	Lactic Acid Buildup in Muscles	9		Constipation	11 10 4		Tingling/Numb Arms or Legs
	Fear of Storms	10 5		Fear of Failure	11		Irritable Bowel Syndrome
	Skin Ulcers Slow to Heal	10 11		Sensitive to Light and Noise	11		Prolapsed or Herniated Discs
	Constantly Feels Cold	10		Child Resists Covers at Night	12		Spinal Surgery
	Flatulence (rotten egg smell)	10		Bladder/Kidney/Gall Infections	12 6		Frozen Shoulder
	Sweat Rash Hands or Armpits	10 8		Burning When Urinating	12 9		Knee Surgery
	Moist Clammy Skin	10		Urinary Tract Infections	12 10		Joint Replacement
	No Energy in Humid Weather	10		Radiation or Chemotherapy			Neurological Disorders
	Wake up Tossing and Turning	10		Cancer			Smoker

MEDICATIONS AND SUPPLEMENTS

Please list all medications and supplements **currently** being taking and for what reason :-

Please list all medications and supplements **previously** taken in recent years (if taken for more than 1 month) and for what reason :-

MENSTRUAL HISTORY

Please indicate in the ☐ boxes below current and past symptoms by inserting either C (current) or P (past)

You can write any additional notes relating to these symptoms in the space provided on page 5

	Bloating	7 8		Bleeding too Frequent	4 2 1 1		Endometriosis	
	Constipation	1 1 10		Heavy Periods Bearing Down	1		Cysts on the Ovaries	
	Diarrhea in Morning	10		Dark Clotted Black Blood	4		Hysterectomy	
	Pre Menstrual Stress	5 7		Bright Red Blood	3		Painful Intercourse	8 3
	Vaginal Dryness	8		Spotting Between Periods			Menopausal Emotional	5 8
	Cramping Pain with Periods	7		Fibroids			Menopausal Hot Sweats	2 3

Current

Age at Onset of Menstruation		How many days in your cycle		Do you take a Contraceptive Pill	
Is your cycle regular		How many days is the bleeding		Duration been taking the C Pill	
				Is Period stopped by the C Pill	

How many Birth Children		
Any complications during pregnancy		
Have you had any Miscarriages		
Trying to fall pregnant but having difficulty		
Have you been through IVF or GIFT		

MEDICAL / EMOTIONAL HISTORY : Provide only as much detail as you are comfortable with

Describe such things as :

Is there stress currently. Rate from 1 to 10 with 10 being the highest stress level			
Was childhood fun or stressful			
Childhood diseases / disorders and medical procedures			
List any accidents			
Adult diseases / disorders and medical procedures			
List any injuries			
Any unusual symptoms			

DIETARY INTAKE :

Please indicate an X in the ☐ boxes below for foods or drinks you crave or have regularly :

	Water			Salty Food	8		Prefer Cold Drinks	6
	Coffee	6 3 7		Spicy Food	2 8		Prefer Hot Drinks	
	Tea	3		Fatty Food	10 6		Intolerances / Allergies	
	Alcohol	4		Cakes / Biscuits / Sweets	9		Celiac Disease	2 3 4
	Soft Drink	2		Chocolate	7		Gluten Intolerance	2 3 4
	Juices bottled			Home Cooked Foods			Milk / Dairy Intolerance	2
	Constantly Thirsty			Take Away Foods			Food Allergies	

Is your daily dietary intake good 25%, 50%, 75% or 90% of the time

Please list your typical daily breakfast, lunch, dinner and snacks including foods and fluids. This is what you do have, not your ideal diet!

Breakfast :

Lunch :

Dinner :

Snacks :

Drinks :

ADDITIONAL NOTES AND INFORMATION :