* All information given on this form is kept strictly confidential and will not be shared with any third party.

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Branch: Staff name:

This form is an essential part of the test; please answer all sections as completely and as accurately as possible.

First name

Mr Mrs Miss Ms

Family name

☎

@

Age:	Weight:	Occupation:

This test is not suitable for children under 2 years of age.

This test is not suitable for immediate & severe reactions

What is your main sign or symptom for taking the test?

…………………………………………………………………………

Do you have any existing or resolved (previous) allergies?

Such as: Milk/ pollen/ wheat/ nuts/ penicillin/ fish/ shellfish/ eggs.

No ☐ Yes ☐ :……………………………………………………

Have you ever had a severe allergic reaction or anaphylaxis?

No ☐ Yes ☐ :……………………………………………………

Do you have a special diet? Vegetarian, vegan, dairy free or…

No ☐ Yes ☐ :……………………………………………………

Tick if you smoke ☐ drink alcohol ☐ exercise ☐ have pet ☐

Please describe frequency of your symptoms as:

Always/**O**ften/**S**ometimes/**R**arely/**N**ever

- Excess gas ……………… A…..O…..S…..R…..N…
- Abdominal bloating……………………………………
- Stomach pain/cramps…………………………………
- Constipation……………………………………………
- Diarrhea…………………………………………………
- Acid Reflux/heartburn…………………………………
- Indigestion………………………………………………
- Irritable Bowel Syndrome (IBS)………………………
- Vomiting…………………………………………………
- Nausea……………………………………………………
- Red/ itchy/ watery eyes………………………………
- Itchy/ tingling lips or mouth…………………………
- Mouth ulcers……………………………………………
- Runny nose………………………………………………
- Sinusitis…………………………………………………
- Sneezing…………………………………………………
- Blocked nose……………………………………………
- Wheezing …………………………………………………
- Hayfever ………………… spring ☐…..summer ☐…..autumn ☐
- Asthma……………………………………………………
- Coughing…………………………………………………
- Shortness of breath ……………………………………

- Painful joints……… A…..O…..S…..R…..N…………
- Aching muscles…………………………………………
- Arthritis……………………………………………………
- Water retention…………………………………………
- Fatigue/tiredness………………………………………
- Swollen lips ☐ ………………tongue ☐ ………………
- Swollen face ☐ ………………throat ☐ ………………

- Anxiety/stress…… A…..O…..S…..R…..N………
- Mood swings……………………………………………
- Depression………………………………………………
- Dizziness…………………………………………………
- Foggy head………………………………………………
- Food craving……………………………………………
- Hyperactivity……………………………………………
- Insomnia…………………………………………………
- Migraines…………………………………………………
- Headaches………………………………………………
- Palpitation………………………………………………
- Panic attacks……………………………………………

- Dry skin……………… A…..O…..S…..R…..N…
- Itching ……………………………………………………
- Redness……………………………………………………
- Broken/ cracked skin…………………………………
- Burning feeling skin …………………………………
- Thickened/scaly skin…………………………………
- Eczema/dermatitis ……………………………………
- Psoriasis…………………………………………………
- Acne………………………………………………………
- Hives/Urticaria (how often?) ………………………
- Rashes (how often?) …………………………………
- Red/itchy spots (how often?)…………………………
- **Which part of your skin is affected?** ……………
- ……………………………………………………………

Are you taking any medication?

No ☐ Yes ☐ :……………………………………………………

……………………………………………………………………

Are you taking any supplements?

No ☐ Yes ☐ :……………………………………………………

……………………………………………………………………

Do you have any other health conditions?

No ☐ Yes ☐ :……………………………………………………

……………………………………………………………………

Terms & conditions

This test is not intended to and does not diagnose or treat a specific disease or assess a specific health condition. We do not take any responsibility that may result from the use of information in this report. Check suitability of the test for your condition by reading the sample guide.

I declare that information given in this report is true to the best of my knowledge and I have read and understood the terms and conditions and accept them.

Signature: ………………………………Date:………………………

Your case will not be processed if the application form is incomplete, without a signature or has not been filled properly and in details.

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