BIO-COMPATIBILITY TESTING

Personal details (as required on your report)
Name: _____ Date of Birth……/……/
…….
Parents Name if child: _____
Address:
_____
_____
Suburb: _____ State: _____ Postcode/Zip: ___
Country: _____
Phone: _____
Email: _____

Please list your symptoms

[ ] Acne/ Rosaeca	[ ] Diarrhoea	[ ] Gout	[ ] Psoriasis
[ ] ADD	[ ] Digestive / Nausea	[ ] Headache	[ ] Rashes / Itchy skin
[ ] Arthritis	[ ] Earache	[ ] Hives	[ ] Reflux
[ ] Asthma	[ ] Excess mucous	[ ] Irritable Bowel	[ ] Restless Legs
[ ] Bad Breath	[ ] Eye infection	[ ] Migraines	[ ] Sinus / Hayfever
[ ] Bloating	[ ] Flatulence	[ ] Muscle Aches	[ ] Sleep Disorders
[ ] Constipation	[ ] Fatigue	[ ] PMS	[ ] Thrush

Other.....

Hair Sample

Please provide a hair sample approx 3cm x 1cm thick
Place hair sample in Glad Wrap or plastic bag.

Please mail the completed form and hair sample to:

Kylie Glover
P.O. Box 191
LANDSBOROUGH Qld 4550

Australia

Please allow 7-10 days for your results to come back.
Kylie will then contact you to schedule your first appointment,

Kylie Glover ND E: kylie@kylieglover.net www.kylieglover.net