

# 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



## 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 1 0	Heavy Periods Bearing Down	1	Cysts on the Ovaries	
Diarrhea in Morning	1 0	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	<b>Intolerances / Allergies</b>	
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 :**