Hair analysis done by a 3rd party not JV health services

Recheck date: Date:

JVHEALTHSERVICES Recheck Form

315 Monumental Circle
Sparks, NV 89436
760-553-6148

Client information:

Name: Phone # Fax # Cell#

Address: City: St. Zip:

E-Mail Referred by:

Date Of Birth: _______________ ; Sex: M / F ;

Occupation____

Any weight problems (trouble losing or gaining)Circle one Y / N

Names of Any you are still taking: Prescription drugs / Supplements / Vitamins / Over the counter drugs; Shots: ____

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On back Journal a sample of YOUR daily diet for 3 days Breakfast, Lunch, Dinner, snacks Include beverages

Have you had tonsils, appendix, gallbladder or anything removed?

Body cleansing and detoxing can aggravate some symptoms. What changes have you noticed since your last analysis.

Better____

Worse____

Same____

Have you eliminated your food sensitivities?

Any questions or concerns you have (use the back if you need more room)