

KATHY WALKER

SALIVA SAMPLE INFORMATION (page 1 of 2)

Name _____ Date Of Birth _____

City & Country Of Birth _____

Age _____ Gender _____

Weight _____ Height _____

Address _____

Tel _____ Fax _____

Describe Current Issue(s) _____

Medical Opinion (If any) _____

Your Opinion (Intuition) _____

Describe How Problem Started _____

Describe Significant Emotional History Related To These Issues _____

Include Environmental Issues Before Or During (If any) _____

Medical History

Childhood Diseases (Circle) Mumps, Measles, Rubella, Chicken Pox, Pneumonia,
Whooping Cough, Scarlet Fever, Other _____

Vaccinations (Circle) Mmr, Dpt, Polio, Chicken Pox, Tb, Other _____

Operations (Include Organs Removed)

Major Health Problems Of Blood Mother & Father _____

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Major Health Problems Of Blood Grandparents _____

Health Problems Of Blood Siblings, Aunts, Uncles

Additional Comments _____

Typical Diet For 2 Days:

Breakfast (Day 1) _____
Lunch (Day 1) _____
Dinner (Day 1) _____
Breakfast (Day 2) _____
Lunch (Day 2) _____
Dinner (Day 2) _____

Mail to: **Kathy Walker**
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Canada M4A 1N6

Call (416) 285-8759 for further details.