

# KATHY WALKER

## HEALTH INFORMATION SHEET (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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**KATHY WALKER**  
SALIVA SAMPLE INFORMATION (Page 2 of 2)

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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Call (416) 285-8759 for further details.