

## BIOCHEMICAL LABORATORIES

### SPECIMEN FOR TRACE METAL ANALYSIS

|                             |     |     |        |        |                   |      |
|-----------------------------|-----|-----|--------|--------|-------------------|------|
| Patient Name (Please Print) | Sex | Age | Weight | Height | Hair Care Product | Date |
|                             |     |     |        |        |                   |      |

DOCTOR INFORMATION      DR. CODE \_\_\_\_\_      Patient's Occupation \_\_\_\_\_

DR. NAME \_\_\_\_\_      Smoker       TEST REQUESTED (check one)

ADDRESS \_\_\_\_\_      Previous test Yes # \_\_\_\_\_      Analysis only      Analysis with Recommendations\*

CITY \_\_\_\_\_ ST \_\_\_\_\_

ZIP \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

#3000 FAX ( ) \_\_\_\_\_

Please check if new address

SAMPLE SOURCE

HEAD

PUBIC

OTHER

|  |                                 |
|--|---------------------------------|
| <input type="checkbox"/> TMA-I (24 metals) | <input type="checkbox"/> TMA-II |
| <input type="checkbox"/> TMS-I (30 metals) | <input type="checkbox"/> TMS-II |
| <input type="checkbox"/> TOX-I (20 metals) | <input type="checkbox"/> TOX-II |
| <input type="checkbox"/> COM-I (35 metals) | <input type="checkbox"/> COM-II |

\* Vitamin, mineral and dietary suggestions.

FOR RECOMMENDATION SELECT VITAMIN COMPANY  GENERIC  OTHER \_\_\_\_\_

PATIENT: PLEASE CHECK NO MORE THAN NINE (9) SYMPTOMS OR DISEASES WHICH ARE APPLICABLE. CHOOSE ONLY THE MOST SIGNIFICANT PROBLEMS THAT YOU NOW HAVE. PLACE 0.5 - 0.9 GRAMS OF HAIR DIRECTLY INTO ENVELOPE. COMPLETE ALL INFORMATION, SEAL AND MAIL.

#### MUSCULO-SKELETAL

- A01 Osteoarthritis
  - A02 Rheumatoid Arthritis
  - A03 Gout
  - A04 Low Back Pain
  - A05 Osteoporosis
  - A06 Scoliosis
  - A07 Joint Pain
  - A08 Muscular Dystrophy
  - A09 Cramps
  - A13 Asthenia (Weakness)
  - A14 Spasms
- #### METABOLIC
- B01 Diabetes Type II
  - B02 Diabetes Type I
  - B03 Hypoglycemia
  - B04 Hyperlipidemia
  - B05 Hyperthyroidism
  - B06 Hypothyroidism
  - B07 Adrenal Insufficiency
  - B08 Edema
  - B09 Obesity
- #### HEMATOLOGICAL
- C01 Anemia
  - C02 Leukemia
  - C03 Lupus

#### CARDIOVASCULAR

- D01 Hypertension
  - D02 Hypotension
  - D03 Arteriosclerosis
  - D04 Rheumatic Heart
  - D05 Varicose Veins
  - D06 Stroke/Aneurysm
  - D07 Hemorrhoids
  - D08 Tachycardia
  - D09 Heart Attack (CVI)
  - D10 Easy Bruising
  - D11 Phlebitis
- #### DERMATOLOGICAL
- E01 Acne
  - E02 Eczema
  - E03 Psoriasis
  - E04 Scleroderma
  - E05 Seborrhea
  - E06 Hair Loss
  - E07 Dandruff
  - E08 Dry Skin
  - E10 Dermatitis
  - E11 Shingles
  - E18 Vitiligo

#### RESPIRATORY

- F01 Asthma
  - F02 Emphysema
  - F03 Bronchitis
  - F04 Sinusitis
  - F05 Hay Fever
  - F06 Shortness of Breath
- #### URO-GENITAL
- G01 PMS (Pre-Menstrual)
  - G02 Post-Menopausal
  - G03 Dysmenorrhea
  - G04 Pregnant
  - G05 Infertility
  - G06 Impotence
  - G07 Prostatitis
  - G08 Kidney Stones
  - G09 Candida/Yeast
- #### GASTRO-INTESTINAL
- H01 Indigestion
  - H02 Constipation
  - H03 Diarrhea
  - H04 Ulcers
  - H05 Gall Stones
  - H06 Hepatitis
  - H07 Pancreatitis
  - H08 Cirrhosis

- H15 Hypogusia
  - H16 Nausea
  - H17 Crohn's Disease
  - H20 Flatulence
- #### MENTAL-NEUROLOGICAL
- I01 Irritability
  - I02 Headache
  - I03 Learning Disorders
  - I04 Hyperactivity
  - I05 Depression
  - I06 Nervousness
  - I07 Anxiety
  - I08 Epilepsy
  - I09 Schizophrenia
  - I10 Parkinson's Disease
  - I11 Multiple Sclerosis
  - I12 Memory Loss
  - I13 Confusion
  - I16 Weakness Arms/Legs
  - I17 Migraine Headaches
  - I18 Menieres Syndrome
  - I21 Tremors
  - I23 Night Sweats
  - I25 Stress

#### MISCELLANEOUS

- J02 Insomnia
  - J03 Cancer
  - J04 Drug Addiction
  - J05 Allergies
  - J06 Fatigue
  - J07 Dizziness (Vertigo)
  - J08 Ear (Tinnitus)
  - J09 Mineral Imbalance
  - J10 Chelation
  - J13 Appetite, Poor
  - J14 Appetite, Excessive
  - J15 Drowsiness
  - J16 No Disorder Present
- #### VISION
- K01 Cataracts
  - K02 Poor Night Vision
  - K03 Light Sensitive
  - K04 Conjunctivitis
  - K06 Excessive Tearing
- #### INFECTIONS
- L01 Chronic Infection
  - L04 Herpes, Simplex
  - L05 Herpes, Zoster
- OTHER \_\_\_\_\_

# BIOCHEMICAL LABORATORIES

## COLLECTION OF A HAIR SAMPLE.



### INSTRUCTIONS:

The best sample is head hair that has not been treated with a perm or dye. If permed or dyed please use pubic hair. To avoid cosmetic affect use thinning shears to cut the hair. This does not leave a cosmetic effect. Thinning shears can be purchased at a beauty salon shop.

#### Short Hair:

- \* Have the patient sit with head slightly forward.
- \* Place napkin or bib around neck to catch hair.
- \* Hold shears diagonally when cutting to avoid cosmetic effect.
- \* Cut 2 or 3 snips at the baso-occipial region (nape of neck).
- \* Comb through hair.
- \* Weight the hair on the balance provided.
- \* Place hair in the sample envelope.
- \* Mail to the lab.

#### Long Hair:

- \* For long hair, part the hair at the ears, pull parted hair to top of head, pin.
- \* Hold shears diagonally when cutting to avoid cosmetic effect.
- \* Cut 2 or 3 snips at the baso-occipial region (nape of neck).
- \* Start combing out the hair at the end of the hair placing it on a table directionally.
- \* Cut off 1 to 2 inches of the newest growth of hair to send to the lab, discard the rest of the hair.
- \* Weight the hair on the balance provided.
- \* Place the hair in sample envelope.
- \* Mail to the lab.

QUESTIONS: PLEASE CALL 1-800-545-6562



COMPLETE THE INFORMATION REQUESTED ON THE ENVELOPE

| SPECIMEN FOR TRACE METAL ANALYSIS  |          |   |   |             |  |               |
|--|----------|---|---|-------------|--|---------------|
| Patient Name (Please Print)  | Sex      | Age   | Weight                                      | Height      | Hair Care Product                          | Date          |
| <b>A SAMPLE</b>  | <b>M</b> | <b>47</b>   | <b>185</b>                                  | <b>5'9"</b> | <b>SELSON BLUE</b>                         | <b>8-8-99</b> |
| DOCTOR INFORMATION   |          | DR. CODE <b>13</b>  | Patient's Occupation <b>Farmer</b>          |             | TEST REQUESTED (check one):                |               |
| DR. NAME <b>Dr. Real E. Good</b>   |          | Smoker <input type="checkbox"/>   | Analysis only                               |             | Analysis with Recommendations*             |               |
| ADDRESS <b>1234 My Street</b>  |          | Previous test Yes <input type="checkbox"/>  | <input type="checkbox"/> TMA-I (24 metals)  |             | <input checked="" type="checkbox"/> TMA-II |               |
| CITY <b>Anytown</b> ST <b>US</b>   |          | SAMPLE SOURCE<br><input checked="" type="checkbox"/> HEAD<br><input type="checkbox"/> PUBIC<br><input type="checkbox"/> OTHER | <input type="checkbox"/> TMS-I (8 minerals) |             | <input type="checkbox"/> TMS-II            |               |
| ZIP <b>12345</b> PHONE <b>(999) 555-1234</b>   |          |   | <input type="checkbox"/> TOX-I (20 metals)  |             | <input type="checkbox"/> TOX-II            |               |
| FAX <b>1</b>   |          |   | <input type="checkbox"/> COM-I (8 metals)   |             | <input type="checkbox"/> COM-II            |               |
| <input type="checkbox"/> Please check if new address   |          |   | * Vitamin, mineral and dietary suggestions  |             |  |               |
| FOR RECOMMENDATION SELECT VITAMIN COMPANY <input checked="" type="checkbox"/> GENERIC <input type="checkbox"/> OTHER _____ |          |   |   |             |  |               |

PATIENT PLEASE CHECK NO MORE THAN NINE (9) SYMPTOMS OR DISEASES WHICH ARE APPLICABLE. CHOOSE ONLY THE MOST SIGNIFICANT PROBLEMS THAT YOU NOW HAVE. PLACE 0.5 - 0.9 GRAMS OF HAIR DIRECTLY INTO ENVELOPE. COMPLETE ALL INFORMATION, SEAL AND MAIL.

- |  |  |  |  |  |
|--|--|--|--|--|
| <b>MUSCULO-SKELETAL</b><br><input type="checkbox"/> A01 Osteoarthritis<br><input type="checkbox"/> A02 Rheumatoid Arthritis<br><input type="checkbox"/> A03 Gout<br><input checked="" type="checkbox"/> A04 Low Back Pain<br><input type="checkbox"/> A05 Osteoporosis<br><input type="checkbox"/> A06 Scoliosis<br><input type="checkbox"/> A07 Joint Pain<br><input type="checkbox"/> A08 Muscular Hypertrophy<br><input type="checkbox"/> A09 Cramps<br><input type="checkbox"/> A13 Asthenia (Weakness)<br><input type="checkbox"/> A14 Spasms<br><b>METABOLIC</b><br><input type="checkbox"/> B01 Diabetes Type II<br><input type="checkbox"/> B02 Diabetes Type I<br><input checked="" type="checkbox"/> B03 Hypoglycemia<br><input type="checkbox"/> B04 Hyperglycemia<br><input type="checkbox"/> B05 Hyperlipidemia<br><input type="checkbox"/> B06 Hypolipidemia<br><input type="checkbox"/> B07 Adrenal Insufficiency<br><input type="checkbox"/> B08 Edema<br><input type="checkbox"/> B09 Obesity<br><b>HEMATOLOGICAL</b><br><input checked="" type="checkbox"/> C01 Anemia<br><input type="checkbox"/> C02 Leukemia<br><input type="checkbox"/> C03 Leukopenia | <b>CARDIOVASCULAR</b><br><input type="checkbox"/> D01 Hypertension<br><input type="checkbox"/> D02 Hypotension<br><input type="checkbox"/> D03 Arteriosclerosis<br><input type="checkbox"/> D04 Rheumatic Heart<br><input type="checkbox"/> D05 Varicose Veins<br><input type="checkbox"/> D06 Stroke/Aneurysm<br><input type="checkbox"/> D07 Hemorrhoids<br><input type="checkbox"/> D08 Tachycardia<br><input type="checkbox"/> D09 Heart Attack (C.V.)<br><input type="checkbox"/> D10 Easy Bruising<br><input type="checkbox"/> D11 Phlebitis<br><b>DERMATOLOGICAL</b><br><input type="checkbox"/> E01 Acne<br><input type="checkbox"/> E02 Eczema<br><input type="checkbox"/> E03 Psoriasis<br><input type="checkbox"/> E04 Scleroderma<br><input type="checkbox"/> E05 Seborrhea<br><input type="checkbox"/> E06 Hair Loss<br><input type="checkbox"/> E07 Dandruff<br><input type="checkbox"/> E08 Dry Skin<br><input type="checkbox"/> E10 Dermatitis<br><input type="checkbox"/> E11 Shingles<br><input type="checkbox"/> E18 Vitiligo | <b>RESPIRATORY</b><br><input type="checkbox"/> F01 Asthma<br><input type="checkbox"/> F02 Emphysema<br><input type="checkbox"/> F03 Bronchitis<br><input type="checkbox"/> F04 Sinusitis<br><input type="checkbox"/> F05 Hay Fever<br><input type="checkbox"/> F06 Shortness of Breath<br><b>URO-GENITAL</b><br><input type="checkbox"/> G01 PMS (Pre-Menstrual)<br><input type="checkbox"/> G02 Post-Menopausal<br><input type="checkbox"/> G03 Dysmenorrhea<br><input type="checkbox"/> G04 Prolapse<br><input type="checkbox"/> G05 Infertility<br><input checked="" type="checkbox"/> G06 Impotence<br><input type="checkbox"/> G07 Prostatitis<br><input type="checkbox"/> G08 Kidney Stones<br><input type="checkbox"/> G09 Female Yeast<br><b>GASTRO-INTESTINAL</b><br><input checked="" type="checkbox"/> H01 Indigestion<br><input type="checkbox"/> H02 Constipation<br><input type="checkbox"/> H03 Diarrhea<br><input type="checkbox"/> H04 Ulcers<br><input type="checkbox"/> H05 Gall Stones<br><input type="checkbox"/> H06 Hepatitis<br><input type="checkbox"/> H07 Pancreatitis<br><input type="checkbox"/> H08 Ulcers | <input type="checkbox"/> I15 Hypoglycemia<br><input type="checkbox"/> I16 Nausea<br><input type="checkbox"/> I17 Crohn's Disease<br><input type="checkbox"/> I20 Flatulence<br><b>MENTAL-NEUROLOGICAL</b><br><input type="checkbox"/> J01 Irritability<br><input checked="" type="checkbox"/> J02 Headache<br><input type="checkbox"/> J03 Learning Disorders<br><input type="checkbox"/> J04 Hyperactivity<br><input checked="" type="checkbox"/> J05 Depression<br><input type="checkbox"/> J06 Nervousness<br><input type="checkbox"/> J07 Anxiety<br><input type="checkbox"/> J08 Epilepsy<br><input checked="" type="checkbox"/> J09 Schizophrenia<br><input type="checkbox"/> J10 Parkinson's Disease<br><input type="checkbox"/> J11 Multiple Sclerosis<br><input type="checkbox"/> J12 Memory Loss<br><input type="checkbox"/> J13 Confusion<br><input type="checkbox"/> J16 Weakness Arms/Legs<br><input type="checkbox"/> J17 Migraine Headaches<br><input type="checkbox"/> J18 Meniere Syndrome<br><input type="checkbox"/> J21 Triggers<br><input type="checkbox"/> J24 Night Sweats<br><input type="checkbox"/> J25 Stress | <b>MISCELLANEOUS</b><br><input type="checkbox"/> K02 Insomnia<br><input type="checkbox"/> K03 Cough<br><input type="checkbox"/> K04 Drug Addiction<br><input type="checkbox"/> K05 Allergies<br><input type="checkbox"/> K06 Fatigue<br><input type="checkbox"/> K07 Dizziness (Vertigo)<br><input type="checkbox"/> K08 Ear (Tinnitus)<br><input type="checkbox"/> K09 Mineral Imbalance<br><input type="checkbox"/> K10 Cerebral<br><input type="checkbox"/> K11 Appetite, Poor<br><input type="checkbox"/> K14 Appetite, Excessive<br><input type="checkbox"/> K15 Drowsiness<br><input type="checkbox"/> K16 No Discomfort Present<br><b>VISION</b><br><input type="checkbox"/> L01 Cataracts<br><input type="checkbox"/> L02 Poor Night Vision<br><input type="checkbox"/> L03 Light Sensitive<br><input type="checkbox"/> L04 Conjunctivitis<br><input type="checkbox"/> L06 Excessive Tearing<br><b>INFECTIONS</b><br><input type="checkbox"/> M01 Chronic Infection<br><input type="checkbox"/> M04 Herpes, Simplex<br><input type="checkbox"/> M05 Herpes, Zoster<br><b>OTHER</b> _____ |
|--|--|--|--|--|

- ◆ Patient's information on top line
- ◆ Dr. Code will be given by the lab
- ◆ Patient's occupation
- ◆ Doctor's information
- ◆ Sample source
- ◆ Test requested
- ◆ Vitamin company if requesting recommendations.
- ◆ Mark no more than 9 applicable symptoms or diseases
- ◆ Place hair in envelope
- ◆ Mail