Hair & Saliva Kit Intake Form

Instructions for Hair/Saliva Kit

A hair/saliva test is recommended. Simply download, print, and fill out this form, then return it by mail with your samples.

1. Take 2 Q-tips and swab the inside of your mouth with both ends before brushing your teeth. Place in a clean plastic baggie. If you do not have hair for a sample, use 4 Q-tips instead.
2. Trim at least 5 strands of hair from the ENDS (not the roots). Place the hair in the same plastic baggie.
3. Place your saliva/hair sample and the completed intake form in an envelope.
4. Mail to:

    Natural Remedy Wellness
    420 Southbrook Circle
    Mankato, MN 56001

5. Please allow up to 30 business days for results. Test results will be emailed.

Service Selection & Pricing

☐ Initial EDS Assessment – Hair & Saliva Kit ($250)

☐ Follow-Up EDS Assessment – Hair & Saliva Kit ($200)

☐ Food Sensitivity Scan – Add-On ($25)

☐ Child Assessment (10 yrs or under – Hair/Saliva Kit Only) ($175)

Payment Method:

☐ **Credit Card** Card Number: _____

Exp Date: _____ Zip: _____ Code: _____

☐ **Enclosed Check**
☐ **Contact Me Upon Receipt** Phone _____ Email _____

Consent & Disclaimer

EDS (ElectroDermal Screening) provides a non-invasive method of gaining valuable information about the vital functions of the body. The primary objective is to disclose patterns of stress and provide energetic feedback that supports a customized program to restore balance.

This DOES NOT provide a medical diagnosis. I understand that the practitioner is not my primary care provider. I give permission for this evaluation and agree that I will not hold Natural Remedy Wellness liable for any personal decisions I make regarding testing or product use.

Signature: _____Date: _____

Print Name: _____ ☐ Signed by Parent or Guardian

Personal Information

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

Date of Birth: _____ Gender: _____

Occupation: _____ Hours per Week: _____

Referred By: _____

Reason(s) for Assessment

Please list your current health concerns or symptoms in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Medical History

Diagnoses (Current or Past):

1. _____
2. _____
3. _____
4. _____
5. _____

Medications:

Name: _____ Frequency: _____ Reason: _____

Name: _____ Frequency: _____ Reason: _____

Name: _____ Frequency: _____ Reason: _____

Name: _____ Frequency: _____ Reason: _____

Name: _____ Frequency: _____ Reason: _____

Vitamins and Supplements:

Name: _____ Frequency: _____ Reason: _____

Name: _____ Frequency: _____ Reason: _____

Name: _____ Frequency: _____ Reason: _____

Name: _____ Frequency: _____ Reason: _____

Name: _____ Frequency: _____ Reason: _____

Known Allergies:

Food(s):_____

Environmental/Other: _____

For women:

☐ I am pregnant.

☐ I am nursing.

☐ I am taking birth control pills or another contraceptive.

☐ I am none of these

Diet and Digestive Health

How often do you poop? _____

Do you experience any of the following?

☐ Bloating, gas, or abdominal discomfort

☐ Heartburn or acid reflux

☐ Undigested food in stool

Do you have any reactions to specific foods (e.g., gluten, yeast)? ☐ No ☐ Yes, please list the foods.

Do you follow a specific diet (e.g., vegetarian, keto)? ☐ No ☐ Yes, please share more.

How many servings of fruits and vegetables do you eat daily? _____

Do you consume processed or fast food regularly? ☐ No ☐ Yes

Lifestyle & Habits

Sleep:

Hours of sleep do you get each night: _____

I wake feeling rested. ☐ No ☐ Yes

Exercise:

How often do you exercise per week? _____

Hydration:

Ounces of water you drink daily: _____

I drink coffee. ☐ No ☐ Yes

I drink tea. ☐ No ☐ Yes

Other Habits:

I smoke. ☐ No ☐ Yes

I drink alcohol. ☐ No ☐ Yes

I am frequently exposed to environmental toxins (e.g., pesticides, cleaning chemicals). ☐ No ☐ Yes

Immune & Health History

How often do you get sick (e.g., colds, flu)? _____

I experience sinus congestion or infections frequently. ☐ No ☐ Yes

I have a chronic or recurrent symptom or infection. ☐ No ☐ Yes

Mental & Emotional Well-being

I often feel stressed, anxious, or overwhelmed. ☐ No ☐ Yes

I have experienced major life changes recently. ☐ No ☐ Yes, please describe what you feel comfortable sharing:

Detoxification and Cleansing

Have you ever done a detox or cleanse? ☐ No ☐ Yes, describe the type of detox or cleanse:

I have a history of liver or kidney issues. ☐ No ☐ Yes

Additional Information

What are your goals for this assessment?

Is there anything else you'd like us to know about your health?