

USA contact

P.O. BOX: not available
 Phone: (1) 941 284 8891
 Fax: (1) 941 706 2603
 www.myfoodtest.com
 info@myfoodtest.com



UNI EN ISO 9001:2008 certified Company for quality



INSTRUCTIONS: after drawing a sample of your hair, put it in a plastic bag. Please, fill in this form by providing all the required data. Follow the payment instructions on the Daphne web site. Mail the form along with the plastic bag to the Daphne Lab USA contact P.O. BOX. Ensure that your signature is readable and the date of the application specified. Please, write in blocks capitals and in a readable form. The customer hereby accepts all the Daphne Biotest legal aspects, which are available on the web site. Every Daphne Meta Biotest result sheet must always be checked and approved by your personal physician.

Family name* Name* Age* Address*

ZIP code* City* State* Home phone*

Mobile Phone Occupation VAT registration or Social security number*

E-mail address Birthplace and Birth date* DAY MONTH YEAR

Which of these profiles best match your body type?

To which one are you aiming?

Have you a good feeling with your body?
 YES NO SOMETIMES

Current weight (lb.)* Height (feet)* Gender* M F Are you currently pregnant? YES NO Are you currently in menopause? YES NO

Did your air sample undergone treatments such as colouring, perming, dyeing? YES NO Blood pressure normal hypotensive hypertensive

Are you actually taking medicines? YES NO (If yes, please write in the Notes section which ones you take, along with any abnormal blood test values) Do you suffer from constipation? YES NO Sometimes

Do you suffer from insomnia? YES NO Do you practice sport? YES NO Which ones and how many times per week? _____

Have you got some allergies? _____

Have you got amalgams, fillings or obturations? YES NO How many _____ Number of cigarettes in a day _____

Indicates the reason for requesting the Biotest: _____

Your favourite food is: coffee bread vegetables meat cereals alcohol pasta fruit fish sugar chocolate pizza legumes dairy products
 (Multiple choices allowed)

Your favourite flavour is: spicy bitter salted sweet sour
 (Multiple choices allowed)

Do you drink a lot of water? YES NO
 How much per day? _____

* mandatory data

DAPHNE METHOD META BIOTEST™ APPLICATION FORM # 62/e - Vers.3.5 - 24/04/2010 VAT Reg. nr. IT06393871212 - R.E.A. Code 812783

CURRENT SICKNESSES

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Acne
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Allergies
<input type="checkbox"/> Alopecia
<input type="checkbox"/> Amenorrhea
<input type="checkbox"/> Anemia
<input type="checkbox"/> Angina pectoris
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Arrhythmias
<input type="checkbox"/> Arteriosclerosis
<input type="checkbox"/> Arthrosis
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Halitosis
<input type="checkbox"/> Autism
<input type="checkbox"/> Gallstones | <input type="checkbox"/> Kidney stones
<input type="checkbox"/> Cancer
<input type="checkbox"/> Candidiasis
<input type="checkbox"/> Capillary
<input type="checkbox"/> Ovarian cysts
<input type="checkbox"/> Colitis
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Depression
<input type="checkbox"/> Dermatitis
<input type="checkbox"/> Diabetes: Type -----
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Learning Disabilities
<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> Dysmenorrhea
<input type="checkbox"/> Cardiac problems
<input type="checkbox"/> Edema | <input type="checkbox"/> Migraine
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Fibroma
<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Gastritis
<input type="checkbox"/> Gout
<input type="checkbox"/> Insomnia
<input type="checkbox"/> Hyperthyroidism
<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Hyperglycemia
<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Raynaud's Disease
<input type="checkbox"/> Flatulence
<input type="checkbox"/> Myasthenia gravis
<input type="checkbox"/> Celiac disease | <input type="checkbox"/> Neuralgia
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Periodontitis
<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Behavioral problems
<input type="checkbox"/> Intestinal problems
<input type="checkbox"/> Prostatitis
<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Meniere's syndrome
<input type="checkbox"/> Constipation
<input type="checkbox"/> Thalassemia
<input type="checkbox"/> Triglycerides
<input type="checkbox"/> Gastric ulcer
<input type="checkbox"/> Varices
<input type="checkbox"/> Dizziness |
|--|---|--|---|

Are you a self-confident person? <input type="radio"/> no <input type="radio"/> Yes <input type="radio"/> Sometimes Are you happy? <input type="radio"/> no <input type="radio"/> Yes <input type="radio"/> Sometimes Is your life stressfull? <input type="radio"/> no <input type="radio"/> Yes <input type="radio"/> Sometimes Do you cry often? <input type="radio"/> no <input type="radio"/> Yes <input type="radio"/> Sometimes	Are you overwhelmed by fears? <input type="radio"/> no <input type="radio"/> Yes <input type="radio"/> Sometimes Did recently occur a death in family? <input type="radio"/> no <input type="radio"/> Yes Have you got frequent nightmares? <input type="radio"/> no <input type="radio"/> Yes <input type="radio"/> Sometimes Have you often guilty feelings? <input type="radio"/> no <input type="radio"/> Yes <input type="radio"/> Sometimes	Do you feel more tired during <input type="radio"/> Morning <input type="radio"/> Afternoon <input type="radio"/> Evening Do you often get angry? <input type="radio"/> no <input type="radio"/> Yes <input type="radio"/> Sometimes Do you vent your anger <input type="radio"/> Within <input type="radio"/> Outside <input type="radio"/> I do not know Is your personality more <input type="radio"/> Outgoing <input type="radio"/> Introvert	Are you more <input type="radio"/> Egoist <input type="radio"/> Altruist Can you describe your determination from 1 to 10? -----	Blood group A <input type="radio"/> AB <input type="radio"/> B <input type="radio"/> 0 <input type="radio"/> RH + <input type="radio"/> - <input type="radio"/> I do not know <input type="radio"/>
---	--	---	---	--

Notes:



Fill in this section only if you have already done a **DAPHNE Meta BioTest™** analysis thema

Since the last time you followed the better worse same as before Which test have you already made with **DAPHNE LAB**? Reports the barcode present on the test that you have already made

In what regard: physical pshychological both

You must Indicate the chosen* **DAPHNE Meta BioTest™**, if you do not make any choices we process the Thema 400:

- thema 400* Food bio-intolerance analysis + food education + natural treatment
- thema 02* Mineral analysis and toxic metals analysis + detoxicating protocol
- thema 03* VMA™ sports test + sports protocol
- thema 06* Gut dysbiosis analysis + re-balancing protocol
- other* -----

I hereby explicitly allow DAPNHE LAB s.r.l. to handle my private and confidential information in compliance with local relevant laws and requirements for informative and statistical purposes and for any other purpose provided for by law.

Place and date *

Readable signature*

Forms not signed or dated will not be processed.

* mandatory data