



UNI EN ISO 9001:2008 certified Company for quality

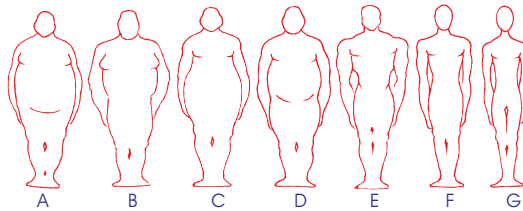


INSTRUCTIONS: after taking a sample of hair, put it in the plastic bag. Fill in this form by providing all the required data. Mail the form along with the plastic bag to the DAPHNE-LAB address. Please call DAPHNE-LAB for payment instructions. Ensure that the signature is legible and that you specified the date of the application. Please write in block capitals and in readable form. The customer hereby accepts all the Daphne Biotest legal aspects, which are available on the Web site or at the Daphne Point outlet. Every Daphne Meta Biotest result sheet must always be checked and approved by your family doctor.

Surname*		Name*		Age*	Address* 							
Postcode*	City*			Country/Area*	Home telephone number* 							
Mobile Phone 		Occupation			VAT registration or Taxpayer's code number*							
E-mail address 				Birthplace and Birth date* <table border="1"> <tr> <td>DAY</td> <td>MONTH</td> <td>YEAR</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>			DAY	MONTH	YEAR			
DAY	MONTH	YEAR										

Which of these best matches your body type?

To which one are you aiming?



Do you have a good relationship with your body?

YES
 NO
 SOMETIMES

Current weight (kg)*	Height (cm)*	Gender* <input type="radio"/> M <input type="radio"/> F	Are you currently pregnant? <input type="radio"/> YES <input type="radio"/> NO	Are you currently in menopause? <input type="radio"/> YES <input type="radio"/> NO
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Has the air sample undergone treatments such as colouring, perming, dyeing? <input type="radio"/> YES <input type="radio"/> NO	Blood pressure <input type="radio"/> normal <input type="radio"/> hypotensive <input type="radio"/> hypertensive
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Do you take medicines? YES NO
(If you do, please write in the Notes section which ones you take, along with any abnormal blood)

Do you suffer from constipation? YES NO Sometimes

Do you suffer from insomnia? YES NO

Do you practice any sport? YES NO *Which ones and how many times per week? _____*

Do you have allergies?

Do you have 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: <input type="checkbox"/> coffee <input type="checkbox"/> bread <input type="checkbox"/> vegetables <input type="checkbox"/> meat <input type="checkbox"/> cereals <input type="checkbox"/> alcohol <input type="checkbox"/> pasta <input type="checkbox"/> fruit <input type="checkbox"/> fish <input type="checkbox"/> sugar <input type="checkbox"/> chocolate <input type="checkbox"/> pizza <input type="checkbox"/> legumes <input type="checkbox"/> dairy products <i>(Multiple choices allowed)</i>	Your favourite flavour is: <input type="checkbox"/> spicy <input type="checkbox"/> bitter <input type="checkbox"/> salted <input type="checkbox"/> sweet <input type="checkbox"/> sour <i>(Multiple choices allowed)</i>	Do you drink a lot of water? <input type="checkbox"/> YES <input type="checkbox"/> NO How many litres per day? _____
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* mandatory data

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?

- no Yes Sometimes

Are you happy?

- no Yes Sometimes

Is your life stressful?

- no Yes Sometimes

Do you cry often?

- no Yes Sometimes

Are you overwhelmed by fears?

- no Yes Sometimes

Did you recently have a death in the family?

- no Yes

Do you have frequent nightmares?

- no Yes Sometimes

Do you experience guilty feelings?

- no Yes Sometimes

Do you feel more tired during

- Morning Afternoon Evening

Do you often get angry?

- no Yes Sometimes

Do you vent your anger

- Within Outside I do not know

Is your personality more

- Outgoing Introvert

Are you more

- Egoist Altruist

Can you describe your determination from 1 to 10?

Blood group

A AB

B 0

RH + -

I do not know

Notes:



SINCERT

IMQ

ESQ CISQ

IQNet

ecoelia

bio test classe M

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

Since the last time you followed the protocol, do you feel: better worse same as before

In what regard: physical pshychological both

Which test have you already made with **DAPHNE LAB**?

Reports the barcode present on the test that you have already made

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 Junior* Food bio-intolerance analysis for children
- thema 02* Mineral analysis and toxic metals analysis + detoxicating protocol
- thema 03* VMA™ sports test + sports protocol
- thema 04* Virus and bacteria bioenergetic test
- thema 05* Organ bioenergetic analysis + organ comparative holographic tables
- thema 06* Gut dysbiosis analysis + re-balancing protocol
- thema 07* Calcium metabolism bioenergetic analysis + supplementary protocol
- thema 08* Water intolerance test + graphs
- thema 09* Toxicity bioenergetic test + bio-architectural Feng-Shui
- thema 10* Bach flowers test + Bach treatment
- thema 11* Iron metabolism bioenergetic test
- thema 12* Gold 3000 test (all the test with a reduction in price)
- thema 13* AntiAging test - bioenergetic analysis of oxidation, polyphenols, anti-free radical
- thema 14* Heart and fat metabolism bioenergetic analysis
- thema Exclusive* Food bio-intolerance analysis + Mineral analysis and toxic metals analysis + Gut dysbiosis analysis
- other* -----

I hereby explicitly allow DAPHNE 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.
Forms not signed or dated will not be processed.

Place and date *

Readable signature*

* mandatory data