



Dr.Kaniappan Padmanaban
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HAIR MINERAL ANALYSIS FORM

Surname	Date of Birth
First Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Street No.:	Height _____ cm Weight _____ kg
Postal Code, Place	Natural Hair Color
Tel	Profession
Email	
Are you a vegetarian or vegan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you often tension?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bullying in workplace?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Suffering from constipation often?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Suffering from dysentery often?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Suffering from the under function of thyroid glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Suffering from the over function of thyroid glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Suffering from chronic liver disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Suffering from chronic Kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Suffering from chronic tiredness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Suffering from depression?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you sensitive?	<input type="checkbox"/> Little <input type="checkbox"/> More <input type="checkbox"/> Lot
How many amalgam teeth fillings do you have?	
Do you eat fish regularly? Sushi?	<input type="checkbox"/> Yes <input type="checkbox"/> No



Are you smoking? If yes, how many per day? Yes No

Water pipes in the house Lead Copper Plastic

Cooking vessels etc. Copper Steel Aluminium

WOMEN:

Pregnancy Yes No

Breast Feeding Yes No

Menopause Yes No

Blood Group

Information about your house / apartment: about every room

Furniture Carpet Wool Synthetic

Paints

Building Material: Lot of woods used in the house?

Electrical and electronic instruments in your house

Garden: Do you use pesticides and fungicides?

Environmental Pollution

What is near your house? Road with lot of traffic

Crossings

Industry

Petrol Bunk

High Power Cables

Andere



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About your working place

Food and Drinks Nothing Little Normal

More

Fish & Seafood Beef Pork

Chicken, Duck & Turkey

Sausage and other meat products

Milk and Dairy Products Milk Cheese Others

Organs Liver Brain

Kidney and Heart

Eggs

Whole Grain Flour

Wheat and Products

Dishes Potato Noodles Rice

Vegetables

Fruits

Dried Fruits

Beans and Pulses

Nuts and Seeds

Sweets

Cakes

Chocolates

Ice Cream

Water

Cola and Soft Drinks



Beer

Wine and other Alcoholic Drinks

Fruit Juice

Vegetable Juice

Salad

Coffee

Tea, Green or Black

Fruit Tea

Herbal Tea

How many liter do you drink in a day?

Fast / Junk Food

Physical Activity

Gym

Jogging

Swimming

Sport

Bicycling

Other _____

Known diseases in the family

High BP

Diabetes 2

Cancer

Others _____

Are you suffering from any disease?

How to feel during a day?



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Are you happy with your sexual life?

What do you understand with Anti-aging

What are the medicines do you take? Prescription medicine, over the counter medicine, vitamins and other food supplements

Do you abuse drugs, for example Cannabis, Kokain, Party Drogen, etc

What do you take for your hair and showering or bathing articles, shampoos etc?

Are your hair coloured? If yes, name of the product, colour and the company name.



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Thank you for your information. Of course, these are treated strictly confidential.
Only our experts have access to the data.

PRIVACY POLICY

By entering and submitting your data, you agree that we will receive, cache and evaluate your information for the purpose of answering your inquiry and any queries. You can revoke this consent at any time.

I hereby confirm the privacy policy

Date

Place

Signature