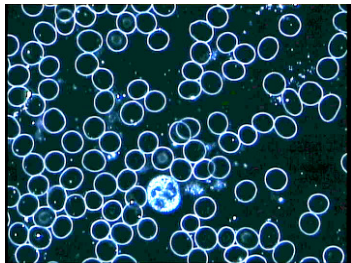
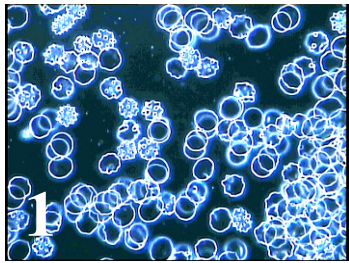


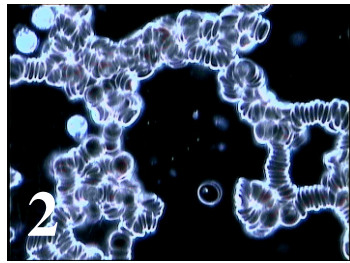
Name:	Vorname:	Geb:	Dat:
Med:	Beschw:	Tagesform:	Kontrolltermin:
Immunsystem:	Belastung:	Organe:	Mangel:



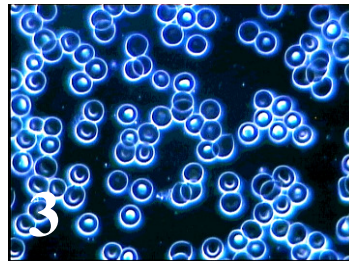
Ideal:



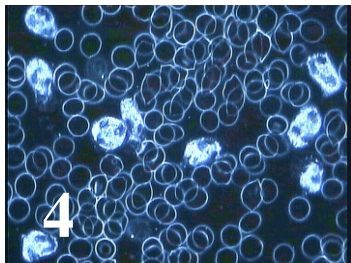
1 Säure/Base: ○○○



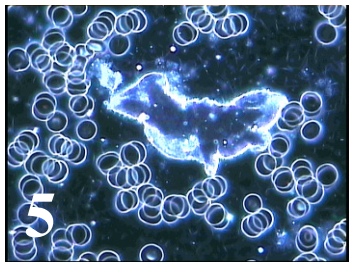
2 Darm/ElektroSmog/
Wasser: ○○○



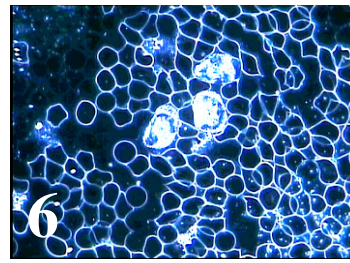
3 Eisenmangel: ○○○



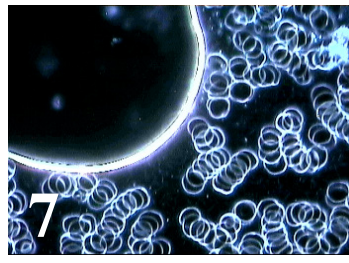
4 Infekt/Allergie: ○○○



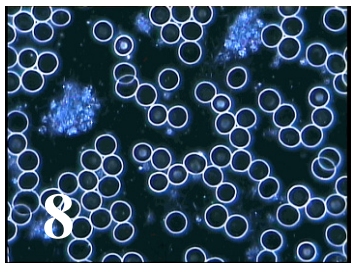
5 Harnsäure/Niere: ○○○



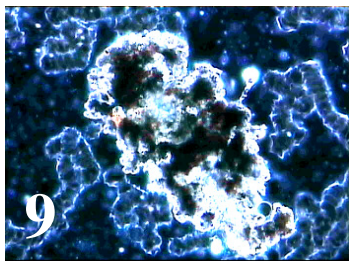
6 Leber: ○○○



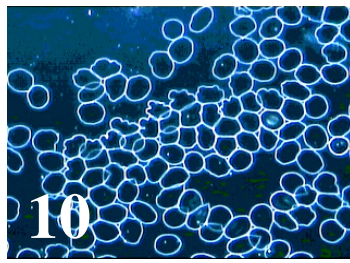
7 Enzyme/Gase: ○○○



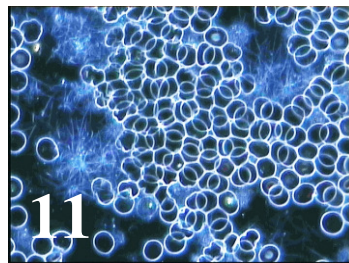
8 Entzündung: ○○○



9 Schwermet.: ○○○



10 Galle/Fette: ○○○



11 Oxid. Stress: ○○○

