REGISTRATION FORM

BASIC INFORMATION

Name

Age + Date of Birth

Gender

Phone Number

Email

Address

Occupation

Relationship Status+Children (if applicable)

Emergency Contact + Phone number

SUPPLEMENTS/MEDICATIONS

Date/Dosage	Supplement/Med + Strength

HEALTH GOALS

MEDICAL HISTORY

PLEASE FILL OUT ANY INFORMATION RELATED TO THE TITLES IN THE BOX, THE MORE INFORMATION PROVIDED, THE MORE I CAN HELP TAILOR PLANS FOR YOU

DAILY ENERGY LEVELS OUT OF 10 AND TIMES IT PEAKS AND TROUGHS

SLEEP QUALITY/DURATION/SLEEP + WAKE TIMES/BEDTIME ROUTINE

STRESS- TYPE/DURATION/TIMES/SYMPTOMS

CURRENT SIGNS + SYMPTOMS

EXERCISE- FREQUENCY/TYPE/DURATION

ENVIRONMENT TOXIN EXPOSURE- PLASTICS/MOULDS/DENTAL WORK/POLLUTION/CHEMICAL EXPOSURE

MOOD + EMOTIONS

RELIGIOUS/CULTURAL/ETHICAL CONSIDERATIONS

FAMILY HEALTH HISTORY

TESTING RSULTS/PATHOLOGY/BLOOD TEST RESULTS/MEDICAL DIAGNOSIS

FAVOURITE FOODS/REGULAR MEALS/DIETARY REQUIREMENTS/TAKEOUT FREQUENCY

ALCOHOL, SMOKING + DRUG USE FRQUENCY/TYPE/DURATION

TOILET HABITS- REGULARITY/COLOUR/QUANTITY/CONSTIPATION/DIARRHOEA BOTH STOOLS + URINE

ADDITIONAL INFORMATION

By filling out this form and sending it to The Art of Harmony Clinic I agree that all information is true and correct, and that if I fail to provide information it could affect desired outcomes. I am motivated and want to help support my journey.

Signed _____