



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

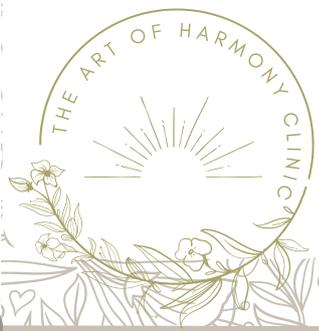
Supplement/Med + Strength

☀️ HEALTH GOALS

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🌙 MEDICAL HISTORY

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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

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

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STRESS-TYPE/DURATION/TIMES/SYMPTOMS

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CURRENT SIGNS + SYMPTOMS

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EXERCISE-FREQUENCY/TYPE/DURATION

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

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MOOD + EMOTIONS

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RELIGIOUS/CULTURAL/ETHICAL CONSIDERATIONS

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FAMILY HEALTH HISTORY

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TESTING RESULTS/PATHOLOGY/BLOOD TEST RESULTS/MEDICAL DIAGNOSIS

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FAVOURITE FOODS/REGULAR MEALS/DIETARY REQUIREMENTS/TAKEOUT FREQUENCY

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ALCOHOL, SMOKING + DRUG USE FREQUENCY/TYPE/DURATION

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**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 _____