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Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Job Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City You Live In: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Which of these have you experienced in the last 6 months?

  Sleeping Difficulties  High Blood Pressure  Digestive Issues / Reflux

* Chronic Fatigue  Mood Swings  Weight Issues / Belly Fat
* Memory Fog  Food Cravings  Headaches
* Weakened Immunity  Poor Concentration  Racing Mind

 Hormonal Issues  Accelerated Aging  Cold Hands &/or Cold Feet

 Anxiety  Depression  Migraines

* Allergies  Low Energy  Vision / Hearing Issues
* Hyperactivity  Dizziness / Vertigo  Constipation
* Numbness  Balance Issues  Jaw Issues / TMJ
* Asthma  Food Intolerance  Gas Pain / Bloating
* Indigestion / Heartburn  Blood Sugar Issues  Skin Conditions / Rash
* Teeth Grinding  Irritable  Poor Emotional Expression

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Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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