Dr Lauren Nappen ORIGINAL MEDICINE
at the heart of healing is hope

The following pages offer a glimpse into your life story. In understanding your biography, your biology comes into greater focus, highlighting those ways of being that no longer serve your best and highest good. Please take your time in filling this out. It is important, as are you.

Personal History and Health Status Questionnaire

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Cell) _____

(Work) _____ (email) _____

Date of Birth: _____

Occupation: _____

Who should we thank for sharing the Original Medicine Healing Sanctuary with you: _____

_____

Please Answer to the Best of Your Ability

1. What do you feel is missing in your life? _____

_____

_____

2. How do you want to know yourself better? _____

_____

_____

3. What truth have you denied that you would like to explore? _____

_____

_____

4. What brings you joy? _____

_____

_____

How do you hope to benefit from care in this office?

Please check any or all that apply.

___ Improvement of my physical symptoms
___ Improvement of my mental/emotional symptoms
___ Improvement of my ability to react or respond to stress
___ Improvement in enjoyment of life and the ability to make constructive choices
___ Overall improved quality of life

Has Wellness Chiropractic Care ever been part of your lifestyle? **Y** _____ **N** _____

Did it meet your objectives? **Y** _____ **N** _____

Your Current Concerns

1. What are your current concerns: _____

2. When did this begin? _____

3. Who have you consulted about this matter? _____

4. Was anything done and did it seem to work? _____

_____

5. What was **different about you** after the treatment? _____

_____

6. What was **different about your condition** after the treatment? _____

_____

7. How aware of this are you during the day? **0 1 2 3** at night? **0 1 2 3**

8. Is there any activity you can be involved with when you totally forget about it? _____

_____

9. What makes you more aware of it? _____

10. Why do you think this has happened or continues to happen to you? _____

_____

11. Do you think this is the sole cause? **Yes** _____ **No** _____

12. If no, what else is involved?

Emotional Areas: _____

Mental/Stress Areas: _____

Spiritual Concerns: _____

13. If this condition or symptom were to go away tomorrow, what would be different about your life?

_____

14. What factors in your current lifestyle/health-style effect your health:

Add: _____

Detract: _____

Willingness to change: **Very** _____ **Maybe** _____ **Maybe Not** _____ **Do I have to?** _____

Childhood Life Stressors

1. Falls/Injuries/Surgeries? _____
   _____
2. Allergies/Asthma/Respiratory Problems: _____
   _____
3. Digestive Problems: _____
   _____
4. Family Stress/Learning Challenges/Emotional Upheaval: _____
   _____

Adult Life Stressors

1. Please grade the following stresses in order of increasing intensity with,

   0: no awareness of stress **1:** slightly stressful **2:** moderately stressful **3:** extremely stressful

   Overall Physical Stress, Trauma: 0 1 2 3
   Includes falls, accidents, injuries, surgeries, repeated postural stress, impacts, physical abuse

   Overall Emotional/Mental Stress: 0 1 2 3
   Includes loss of loved ones, rapid change in life situation, abuse (mental, emotional, physical, sexual) legal, financial, work/career changes, separation/divorce, stress of illness

   Overall Chemical Stress: 0 1 2 3
   Includes drugs, medications, smoke, fumes, additives, work environment

2. Any other health/diagnosis related challenges: _____
   _____

3. Prescribed Medications including Medical Marijuana
   Illness: _____ Medication: _____
   Illness: _____ Medication: _____
   Illness: _____ Medication: _____
   Illness: _____ Medication: _____

4. Please List Most Current Supplements: _____
   _____
   _____

   Who Recommended? Primary Care _____ Other _____
   Most Recent Bloodwork? _____

5. Anything that was not asked that you feel is relevant? _____
   _____
   _____
   _____
   _____

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Disclosure & Terms of Acceptance

The approach of Dr. Lauren's Original Medicine (inclusive only of the tools used in her office) is in no way a replacement for appropriate medical or psychiatric care. It is your responsibility to disclose any relevant diagnosis/medications to the work you will be doing.

It is clearly understood that there is no promise or offer of any kind, on the part of the doctor or this office to treat any symptom, condition, or disease. We focus on restoring communication within you, which allows the greatest opportunities for growth and healing. The care offered in this office is designed to empower how you move and live in this life. It is under these parameters that you consent to receive care in this practice, for yourself or your child. Should you feel that a different approach is needed for yourself or your child it is your right and responsibility to follow that inner guidance.

Insurance

Dr. Lauren's Original Medicine provides a comprehensive level of care that is not adequately recognized by major medical insurance carriers and is out-of-network with all insurance. As a courtesy, at the end of each month, the office will electronically submit any paid invoice for chiropractic care only. To find out more about your out-of-network benefits, please call your provider member number on the back of your insurance card. This office does not write reports to justify chiropractic care, nor does it work with personal injury claims.

Cancellation Policy

Thank you in advance for cooperating with the 24-hour cancellation policy. Should you be unable to comply, you will be billed for the scheduled service in full. In the case of inclement weather these fees do not apply. You may call the office directly or **text the office cell phone*** (215-815-2729) to re-schedule or change your appointment.

**Cell Phone Etiquette*

The office cell phone is available for texting purposes only, as well as for any true emergency. If you need to cancel your appointment, please do so during regular business hours at least 24 hours in advance. Dr. Lauren won't be able to respond to late night texts or appointments for these purposes. If you need to connect with her for any other reason, please schedule a Certainty Session by calling 215-794-0606 or emailing her at drlaurennappen@gmail.com.

Client Name: _____ Date: _____

Client Signature: _____

Child Name: _____ Parent Name: _____

Parent Signature: _____

Witness: Date: _____