



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 & my ability to react or respond to stress
- \_\_\_ Improvement in enjoyment of life and the ability to make constructive choices
- \_\_\_ Greater understanding of my spiritual nature as it relates to my life
- \_\_\_ Overall improved quality of life

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 concern 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 concern 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**

Accidents, injuries, surgeries, repeated postural stress, impacts, physical abuse etc.

**Overall Emotional/Mental Stress: 0 1 2 3**

Grieving and loss, rapid change in life situation, abuse challenges, career shifts, relationship issues.

**Overall Chemical Stress: 0 1 2 3**

Medications, drug/alcohol, smoke, fumes, additives, work environment etc.

2. Any other health/diagnosis related challenges: \_\_\_\_\_  
\_\_\_\_\_

3. Prescribed Medications including Medical Marijuana

Illness: _____	Medication: _____
Illness: _____	Medication: _____
Illness: _____	Medication: _____
Illness: _____	Medication: _____

4. Has Wellness Chiropractic Care ever been part of your lifestyle? Y \_\_\_\_\_ N \_\_\_\_\_  
Did it meet your objectives? Y \_\_\_\_\_ N \_\_\_\_\_

5. Please List Most Current Supplements: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who Recommended? MD \_\_\_ Other \_\_\_ Most Recent Bloodwork? \_\_\_\_\_

6. Anything that was not asked that you feel is relevant? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Disclosure & Terms of Acceptance

Please read the following carefully for our work together.

The transformative approach of the tools used in this office is in no way a replacement for appropriate medical, psychological or psychiatric care. It is your responsibility to disclose any relevant diagnosis/medications to the work you will be doing in this office.

#### 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.
- That the focus is on clearing and releasing patterns of consciousness, creating the greatest opportunities for growth, healing, and manifestation of desired goals. The care offered in this office is designed to empower how you move and thrive in your life.

#### Cancellation Policy

While scheduling challenges do occur, we 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, whether virtual or in person.

##### Exceptions for Inclement Weather On-Site:

- Spiritual Coaching/Counseling sessions may be shifted to virtual.
- Hands-on energy medicine will be rescheduled entirely.

##### To Reschedule/Change Appointment:

- Call the office directly: 215-794-0606
- Text the office cell phone: 215-815-2729

#### A Note About Insurance

The comprehensive level of wellness care offered through coaching, spiritual counseling and inner alignment is not recognized by major medical insurance carriers and is out-of-network with all insurance.

- **Chiropractic Care:** If your Original Medicine care includes chiropractic wellness adjustments, as a courtesy the office will electronically submit any paid invoice at the end of each month. This office does not write reports for any insurance company, nor does it handle personal injury cases.
- **Medicare Eligible/Dependent:** Medicare does NOT cover wellness care/chronic care of any kind. Should reimbursement be important to you, you are free to work with someone who works within the Medicare guidelines.
- **Nutritional Support:** Receipts are available for eligible expenses through your HSA when purchased directly from this office only.

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 responsibility to follow that inner guidance.

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_

Child Name: \_\_\_\_\_ Parent Name: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Witness: Date: \_\_\_\_\_