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? ______________________

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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 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. 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? Primary Care _____ Other _____
Most Recent Bloodwork? ____________________

5. 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 Original Medicine (inclusive only 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:

- Original Medicine 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
  ****Cell Phone Etiquette**: Late night texts will be answered the following day.*
  If you have a true emergency, please go to the nearest ER.
- Reschedule Online

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.
- 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: ____