Heart of Transformation

Wellness Institute, S. C.

1618 Orrington Ave. Suite 206 Evanston, Illinois 60201 Phone (847) 425-9355

PROTECTING YOUR RIGHT TO PRIVACY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We at **Heart of Transformation Wellness Institute, S. C.** respect client confidentiality and only release information about you in accordance with Illinois and Federal law. This notice describes our policies related to the use of the records of your care generated by this practice.

As you review this information, please be aware that because we are a small independent practice and your treatment here is almost exclusively contained in the relationship you have with your Health Care Provider, significant portions of the law may not affect you under most circumstances. Also because we handle all client billing in house and do not use the Internet for any client information, and information related to you is closely monitored by your Health Care Provider.

These privacy practices are for **Heart of Transformation Wellness Institute, S. C.** and all Independent Contractors with whom we have valid contact. Any questions about this policy or you rights should be directed to your Health Care Provider (who act as your privacy officer for her/his practice) or to Archana Lal-Tabak MD. (847) 425-9355, 1618 Orrington Ave. Suite 206 Evanston, IL 60201.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION. In order to effectively provide you care, there are times when we will need to share your medical/treatment information with others inside or outside of our practice. This includes for

Treatment we may use or disclose medical/treatment information about you to provide, coordinate, or manage your Care or any related services, including sharing information with others that we are consulting with or referring you to.

Payment. Information will be used to obtain payment for the treatment and services provided. This may include contacting your health insurance company for prior approval of planned treatment of for billing purposes.

Healthcare Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments or reviewing your care.

INFORMATION DISCLOSED WITHOUT YOUR CONSENT. Under Illinois and Federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.

As Required by Law. This includes situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect, as in child or elder abuse.

Coroners, Funeral Directors, and Organ Donation. We may disclose information to these individuals as needed for the purposes of carrying out their duties.

Government Requirements. We may disclose information to a health oversight agency of activities authorized by law, such as audits, investigations inspections and licensure. We are required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend or prosecute the criminals. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

PATIENT RIGHTS. You have the following rights under Illinois and Federal law:

Copy of Record. You are entitled to inspect the treatment record our practice has generated about you. We may charge you a reasonable fee for copying and mailing your record.

Release of Records. You may consent in writing to release your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction of Record. You may ask us not to use or disclose part of the treatment information. This request must be in writing. Your health care provider is not required to agree to your request if it is believed that it is in your best interest to permit use and disclosure of the information. Direct your written request to your Heath Care Provider.

Contacting you. You may request that we send information to another address or by alternative means. We will honor reasonable requests and reserve the right to verify that any payment information you are providing is correct.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this, please contact your Health Care Provider. In certain cases we may deny your request. If we deny your request for an amendment you have a right to file a statement that you disagree with us. We will then file our response and your statement and our response will be added to your record.

Accounting for Disclosures. You may request an accounting of any disclosures we have made related to your medical information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific authorization to release. It also excludes information
we were required to release. To receive information regarding disclosure made for a specific time period on longer than six years and after April 14, 2003, please submit your request in writing to your Health Care Provider.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints you may contract your Health Care Provider in writing at our mailing address above for further information. You also may complain to the Secretary of Health and Human Services if you believe your Health Care Provider or Heart of Transformation Wellness Associates has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. Heart of Transformation Wellness Associates and your Health Care Provider Reserve the right to change this Privacy Policy passed on the needs of the Practice and changes in State and Federal law.

Please note that you are responsible for payment of all services at the time they are provided regardless of what you are paid by your insurance company. Thank you.

Client/Guardian Signature:_____ Date:_____

Health Care Provider Signature:_____ Date:_____

NEW PATIENT REGISTRATION

Heart of Transformation Wellness Institute, S. C.
1618 Orrington Ave. Suite 206
Evanston, IL 60201 (847) 425-9355

PATIENT INFORMATION

Today's date:

Last Name: _____ First Name: _____ Middle Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: (_____)_____-_____ E-Mail: _____ Fax #: (_____)_____-_____

Birthdate: ____/____/____ Age: _____ Social Security #: _____-_____-_____ Gender: Male ____ Female ____

Occupation: _____ Student Status: Full Time: _____ Part Time: _____ Does Not Apply : _____

Employer: _____ Work Telephone : (_____)_____-_____

Employer Address: _____ City: _____ State: _____ Zip: _____

RESPONSIBLE PARTY INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____ Street Address: _____

City: _____ State: _____ Zip: _____ Home Telephone: (_____)_____-_____ E-Mail: _____

Birthdate: ____/____/____ Age: _____ Social Security #: _____-_____-_____ Gender: Male ____ Female ____

Occupation: _____ Relationship to patient: Self ____ Spouse ____ Partner ____ Dependent ____

Employer: _____ Work Telephone: (_____)_____-_____ Employer Address: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance _____

Address _____

City _____ State _____ Zip _____

Insured Name _____ Date of Birth _____

Policy I.D. # _____ Group #: _____

Secondary Insurance _____

Address _____

City _____ State _____ Zip _____

Insured Name _____ Date of Birth _____

Policy I.D. #: _____ Group # _____

OTHER INFORMATION

Illness/Injury is job related: _____ Yes _____ No

If yes, Date of Injury: _____

Employer: _____

Employer Contact: _____

Employer Phone #(_____)_____-_____

Illness/Injury related to an accident?: _____ Yes _____ No

If yes, Date of Accident: _____

Do you have an attorney?: _____ Yes _____ No

Attorney Name: _____

Attorney Phone #: (_____)_____-_____

How did you hear about our office: ____Yellow Pages __Personal Reference (Name): _____ Other: _____

IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Address: _____

City : _____ State: _____ Zip: _____ Telephone #: (_____)_____-_____

PRIMARY HEALTH CONCERN: _____

I HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS TRUE AND CORRECT.
I UNDERSTAND THAT REGARDLESS OF INSURANCE COVERAGE, I AM ULTIMATELY RESPONSIBLE FOR ALL SERVICES PERFORMED.

PATIENT SIGNATURE _____ DATE _____

NEW PATIENT INTAKE FORM

Welcome to Heart of Transformation Wellness Institute S. C. Please complete the following form. This is a confidential record. Information contained in this document will not be released to anyone without your authorization.

Personal History Form **Date**_____

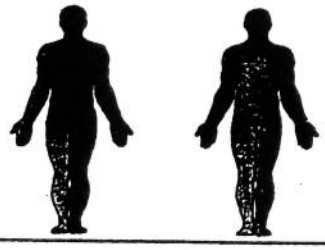
Name: _____

Date of Last Physical Exam_____ Your Doctor: _____Referred by: _____

MAIN PROBLEMS/ REASONS FOR THIS APPOINTMENT: **(if possible, rank in terms of importance to you)**

1. _____
2. _____
3. _____
4. _____
5. _____

Please mark your areas of pain / discomfort on the figures:



Is your condition getting worse? ☐ Yes ☐ No

Is your discomfort ☐ Constant or ☐ Off and on

Have you seen other doctors for these conditions? ☐Yes ☐No

(If yes, please list doctor, prior interventions, treatments medication and treatment dates.)

_____

_____

_____

Have you experienced any accidents or falls within the: ☐ Past Year ☐Past 5 Years ☐Never

(If you have experienced an accident, what type was it? ☐Auto ☐ Work ☐Home ☐ Sports ☐ Other)

Briefly explain:

_____

_____

_____

ALLERGIES:

_____

_____

HEALTH SCREENING HISTORY

Mammogram_____ Pap Smear_____ Self Breast Exam_____ Breast Exam by Doctor_____ Blood test for Anemia_____

Blood test for Cholesterol_____ Other Blood Tests_____

Immunizations: Polio_____Tetanus_____Hepatitis_____Pneumonia_____Flu Shot_____

Test for Blood in stool_____ Rectal Exam _____Feeling the Prostate _____Scope Lower Bowel_____

Self Exam Testicle_____ Testicle Exam by Professional_____ P_____G_____

Patient Name: _____

Current Medications (Include Pain Killers, Muscle relaxers, Aspirin, Tranquilizers, Birth Control pills)	Dose	Times / Day

Current Herbs / Vitamins/ Supplements	Dose	Times / Day

PAST MEDICAL HISTORY (Prior illness, injury, hospitalization, surgery, trauma)

Reason:	Date:

PERSONAL AND FAMILY HISTORY (check those that apply)

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Breast Cancer							
Cancer							
Colon Cancer							
Depression							
Drug Abuse							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood Pressure							
Irritable Bowel Syndrome							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							

Patient Name: _____

Patient reports symptoms that currently apply to you:

Constitutional	Ears, Nose, Mouth, & Throat	Muscles, Bones, Joints	Digestion & Intestine	Eyes	Immune System	Blood System
__poor appetite	__headaches	__neck pain	__indigestion	__blurred vision	__too many infections	__anemia
__fevers	__jaw clicks	__back pain	__belching	__eye pain	__allergies to food	__easy bruising
__chills	__grinding teeth	__muscle pain	__heartburn	__poor vision day night	__allergies to environment	__chest pain
__food cravings	__trouble chewing	__painful joints: Right Left	__difficulty swallowing	__wear corrective lenses	__lymph gland swelling	__lightheaded
__weight loss	__facial pain	__shoulder	__nausea	__nearsighted	__other	__palpitations
__weight gain	__sore throat	__elbow	__liver trouble	__farsighted		__cold hands or feet
__fatigue	__mouth sores	__hip __knee	__vomiting	__other		__fainting
	__bad breath	__ankle	__diarrhea			__swelling feet
	__ringing ears	__wrist __finger	__cramping bowels			__blood clots
	__nosebleed	__joint swelling	__gassy gut			__varicose veins
	__postnasal drip	__muscle weakness	__constipation			
	__sinus problems	__muscle cramps	__abdominal pain			
	__trouble with taste/ smell		__rectal pain/itching			
	__poor hearing		__hemorrhoids/ piles			
	__earaches		__blood in stool			

Respiratory & Lungs	Sexual Organs	Skin, Hair, Breast	Nerves, Brain, Movement	Women	Urinary & Bladder	Men
__shortness of breath	__sores on genitals	__breast lumps or pain	__seizures	__pelvic pain	__painful urination	__age period started
__wheezing or asthma	__lumps or swelling	__breast leaks fluid	__nerve pain	__vaginal discharge	__wake up to urinate	__# of pregnancies
__repeated colds/flu	__erection problems	__rashes	__poor balance	__painful periods	__kidney stones	__pregnancies lost
__cough dry/ irritating	__poor sexual response	__itching, hives	__poor coordination	__premenstrual syndrome	__loss of bladder control	__past fertility problems
	__infertility	__hair loss	__tremors or shaking	__hot flashes	__frequent urination	__# of live births
	__repeated infections	__dry skin, eczema		__itching or soreness	__sudden urge to urinate	__children currently living
					__blood /puss in urine	__age menopause

Patient Name: _____ Page 4 0f
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SOCIAL HISTORY (check those that apply):

Marital status:	Education level completed:	Memories of your childhood	Do You Find Your Life
☐ single	☐ high school	☐ Mostly happy	☐ Generally Unsatisfactory
☐ married	☐ college	☐ Mostly painful	☐ Too Demanding
☐ Divorced	☐ professional school	☐ Normal	☐ Boring
☐ other :	☐ other:	☐ don't recall	☐ Satisfactory

Living arrangement:

☐ alone ☐ family ☐ roommate ☐ other

☐ children (list ages):

☐ Major stresses in last 6 months ☐ Money ☐ Job ☐ Marriage ☐ HomeLife ☐ Children

☐ other:

LIFESTYLE/ SELF-CARE ISSUES

Do you smoke cigarettes?	☐ YES ☐ NO	If yes, how many?	_____ packs per day
Did you ever smoke?	☐ YES ☐ NO	If yes, when did you quit?	_____
Do you drink alcohol?	☐ YES ☐ NO	If yes, how much?	_____ drinks per week
Do you drink caffeinated beverages?	☐ YES ☐ NO	If yes, which?	_____
Do you use recreational drugs?	☐ YES ☐ NO	If yes, which?	_____
Do you manage stress well?	☐ YES ☐ NO	☐ NOT SURE	☐ NEED HELP
Do you exercise regularly?	☐ YES ☐ NO	If no, why?	_____
Do you enjoy your job?	☐ YES ☐ NO	If no, why?	_____
Do you allow time to unwind and relax?	☐ YES ☐ NO	If no, why?	_____
Do you sleep soundly?	☐ YES ☐ NO	If no, why?	_____
Are you satisfied with your sex life?	☐ YES ☐ NO	If no, why?	_____
Are you satisfied with your social life?	☐ YES ☐ NO	If no, why?	_____
Are you satisfied with your spiritual life?	☐ YES ☐ NO	If no, why?	_____
Is your diet healthy enough?	☐ YES ☐ NO	☐ NOT SURE	☐ NEED HELP

Typical breakfast _____

Typical lunch _____

Typical dinner _____

Typical snacks _____

Devices
Do You Use:

___Eyeglasses	_____Contact Lens	_____Hearing Aid	_____Dentures
___Brace (Neck, Back)	_____ Pacemaker	_____ IUD, Diaphragm	_____Artificial Limbs

YOUR PRIMARY CARE DOCTOR'S NAME _____ **DR's PHONE #** _____

YOUR PRIMARY CARE DOCTOR'S ADDRESS _____

MAY WE CONTACT YOUR REGULAR OR REFERRING DOCTOR? _____

☐ **I have reviewed and confirmed the information with the patient**

_____
Physician Signature **Date**

MAHARISHI VEDIC UNIVERSITY
Maharishi Vedic Medicine Course for Health Professionals

Ama Questionnaire

Please indicate below to what degree the following statements apply to you
(1 is never or very rarely, 5 is always or almost always):

1. I tend to feel a sense of blockage or obstruction in the body (constipation, congestion in the head area, general feeling of non-clarity, etc.) 1 2 3 4 5
2. When I wake up in the morning, I do not feel clear; it takes me quite some time to feel really awake. 1 2 3 4 5
3. I tend to feel physically weak for no apparent reason. 1 2 3 4 5
4. I catch cold or similar ailments several times a year. 1 2 3 4 5
5. I tend to feel heaviness in the body. 1 2 3 4 5
6. I tend to feel that something is not functioning properly in the body (breathing, digestion, elimination, or other). 1 2 3 4 5
7. I tend to be lazy, e.g., no inclination to work. 1 2 3 4 5
8. I often suffer from indigestion. 1 2 3 4 5
9. I feel the need to expectorate frequently. 1 2 3 4 5
10. Often I have no taste for food, or no real appetite. 1 2 3 4 5
11. I tend to feel tired or exhausted, mentally and physically. 1 2 3 4 5

Total score: _____

Bach Flower Essences Self-Help Questionnaire

The following questionnaire was developed from the original writings of Dr. Edward Bach and is provided for your interest and self-assessment. Please print out and read and answer each of the questions carefully. After completing the Questionnaire in full, refer to the answer key at the bottom of page. Check only those questions for which you gave a definite YES answer. If your answer is NO or SOMETIMES, leave the box blank.

( ) 1. Do you have vague fears which you cannot explain?

( ) 2. Do you often find yourself distressed and anxious, but are unable to put your finger on the problem?

( ) 3. Do you wake with a sense of apprehension and foreboding, feeling that something bad may happen, but don't know what it may be?

( ) 4. Do you have specific fears which you can identify and would like to overcome?

( ) 5. Are you shy and easily frightened by particular circumstances and things?

( ) 6. When faced with situations or things that frighten you, do you become nervous and too paralyzed to act?

( ) 7. Do you fear losing control of your mind or body?

( ) 8. Are you compulsive, or have impulses to do things you know are wrong but have difficulty controlling your actions?

( ) 9. Do you fear losing control and hurting yourself or others?

( ) 10. Do you worry over the health and safety of your friends and family?

( ) 11. Do you fear that something may happen to those close to you?

( ) 12. Does your over-concern and worry for others cause you considerable distress?

( ) 13. Do you suffer from extreme terror?

( ) 14. Do you tend to panic and become hysterical?

( ) 15. Are you troubled by nightmares?

( ) 16. Do you lack confidence in your ability to judge things on your own and make decisions?

( ) 17. Do you find yourself asking other people's advice, even when you know what you want?

( ) 18. After taking advice from others, do you find yourself confused by the choices, constantly changing your direction according to the latest recommendations?

( ) 19. Do you suffer from indecision, uncertainty or hesitancy?

( ) 20. Do you have difficulty choosing between one thing and another?

( ) 21. Do you experience extreme mood swings, or have difficulty in keeping your balance?

( ) 22. Are you dissatisfied with your current role in life, feeling that life is passing you by?

( ) 23. Have you tried many different directions in life, but nothing seems to bring satisfaction?

( ) 24. Would you like to find a new lifestyle, career or change your old one, but have difficulty deciding what you should be doing?

( ) 25. Do you lack confidence?

( ) 26. Do you not try things for fear of failing?

( ) 27. Do you feel inferior, and that others are more capable and qualified than you?

( ) 28. On rising in the morning, do you find yourself tired, not wanting to get up?

( ) 29. Do you feel some part of you needs to be strengthened before you can tackle the day?

( ) 30. Do you find once you have started your daily activities your tiredness is forgotten, and you're able to complete your task?

( ) 31. Are you absentminded, or does your attention easily wander, making it difficult to concentrate?

( ) 32. Do you find you have little interest in present circumstances, often daydreaming, wishing you were somewhere else?

( ) 33. Do you find yourself dozing off frequently, regardless of where you are?

( ) 34. Do you find you are caught between living in the present and dwelling in memories of the past?

( ) 35. Are there things you would like to have done with your life but never had the opportunity to do?

( ) 36. Do you find yourself reminiscing about the good old days, wishing you were able to live your life over again?

( ) 37. Do you find you are indifferent and apathetic toward life?

( ) 38. Are you resigned to your current circumstances, making little effort to improve things or find joy?

( ) 39. Do you feel you've given up and don't care one way or another what happens?

( ) 40. Do you find you can't sleep because your thoughts give you no rest?

( ) 41. Do you find your head full of persistent, unwanted thoughts that prevent concentration?

( ) 42. Do you relive unhappy event or arguments over and over again?

( ) 43. Do you find you don't learn from past experiences, repeating the same mistakes or patterns of behavior?

( ) 44. Due to lack of observation, do you find it necessary to go over things already done?

( ) 45. Is there a particular situation or condition continually recurring in your life which you would like to overcome?

( ) 46. Are you now going through, or have you recently gone through, an illness or personal ordeal which left you physically and mentally drained?

( ) 47. Do you tire easily with no reserve energy to complete your tasks or enjoy the day?

( ) 48. Do you feel sapped of strength and vitality, where even the least effort exhausts you?

( ) 49. Do others find you aloof, prideful and at times condescending?

( ) 50. Do you keep to yourself, not wishing to be interfered with or to interfere in other people's affairs?

( ) 51. Are you self-reliant? Do you prefer spending your time alone?

( ) 52. Do you find yourself losing patience, becoming tense and irritable with people and things that move too slowly for you?

( ) 53. Do you do things in a rush, racing from one place or situation to another?

( ) 54. Do you find you need to work alone, because others can't keep up to your pace?

( ) 55. Do you find others avoiding conversation with you because you tend to talk a great deal?

( ) 56. Do you dislike being alone and seek the company of anyone willing to listen to your troubles?

( ) 57. Do you feel the need to steer conversations back to your special interests or problems? Are you reluctant to discontinue them even when the listener has to leave?

( ) 58. When worried or in pain, do you tend to conceal it from others, making light of even the most trying of circumstances?

( ) 59. Do you go out of your way to avoid burdening others with your problems, giving in to the wishes of others in order to avoid an argument or quarrel?

( ) 60. When troubled, do you find yourself drinking alcohol, or using stimulants or drugs to assist in keeping up a happy disposition?

( ) 61. Are you easily imposed on because of your willingness to help others?

( ) 62. Is it difficult for you to say no when you're asked for help, becoming more a servant than a willing helper?

( ) 63. Do you neglect your own needs, because you are too busy taking care of other people's needs?

( ) 64. Are you involved in a relationship or situation you would like to be free of, but cannot break away from?

( ) 65. Are you currently in a state of transition or change?

( ) 66. In the midst of this change, do you find that you're having difficulty in letting go of past attachments or in starting new beginnings?

( ) 67. Are you suspicious and mistrusting of other people's motives and intentions?

( ) 68. Do others find you spiteful, envious, jealous or vengeful?

( ) 69. Do you find yourself lacking compassion or warmth toward others?

( ) 70. Are you rarely content with your accomplishments, feeling that you could always do better?

( ) 71. Do you blame yourself for other people's mistakes, feeling that their shortcoming are in some way your fault or responsibility?

( ) 72. Are you hard on yourself when you fail to live up to the standards or expectations you've set for yourself?

( ) 73. Do you tend to overextend your commitments?

( ) 74. Do you find yourself overwhelmed by your work, and despite being capable feel you have taken on more than you can do?

( ) 75. Do you become despondent when faced with the magnitude of your responsibilities?

( ) 76. Have there been past traumas or shocks in your life, which you may not have completely recovered from?

( ) 77. Do you feel a past surgery or accident is responsible for your present condition?

( ) 78. Have you recently, or in the past, suffered a personal loss which you haven't quite gotten over?

( ) 79. Do you feel you've reached the limits of your endurance, and there's nothing but annihilation left to face?

( ) 80. Do you suffer from mental anguish and deep despair?

( ) 81. Do you feel that the burden of life is more than you can bear?

( ) 82. Have you lost hope that you will recover from or be helped in overcoming an illness or difficulty?

( ) 83. Do you feel it is useless to seek further help for your problem?

( ) 84. Have you given up hope that things will change for the better in some circumstance or situation in your life?

( ) 85. Do you ever become gloomy and depressed for no known reason?

( ) 86. Does this depression envelope you like a dark cloud, hiding the joy of life?

( ) 87. Do you find this gloom and depression, for no apparent reason, lifts as suddenly as it comes?

( ) 88. Are you easily discouraged when things don't go your way?

( ) 89. When setting out to accomplish a task, do you become over-sensitive to small delays or hindrances which may lead to self-doubt, and at times to depression?

( ) 90. Is it hard for you to start over again once you've encountered difficulties?

( ) 91. Are you one who tirelessly struggles on despite oppositions and delays?

( ) 92. Can you always be depended on to complete what you set out to do, regardless of the challenge?

( ) 93. Do you tend to throw yourself into your projects neglecting your own needs, as well as the needs of those close to you?

( ) 94. Through no fault of your own, do you feel that life has been unfair or unjust to you?

( ) 95. Have you become resentful and bitter toward those who may have treated you poorly?

( ) 96. Despite all you have done, do you feel your best efforts have largely gone unrewarded, while others not as deserving as yourself, have gained?

( ) 97. Do you feel unclean or ashamed over an act you should not have committed, or over someone or something have violated you personally?

( ) 98. Do you find yourself preoccupied with small physical problems suc

( ) as pimples, small blemishes or rashes, while overlooking more serious conditions?

( ) 99. Do you feel there is something wrong with, or some things you would like changed, in your physical appearance?

( ) 100. Are you compulsive about cleanliness, even at times to the extreme?

( ) 101. Are you afraid of becoming, or feel you have already become, contaminated and need to be cleansed?

( ) 102. Are you possessive of those close to you and feel you know what's best for them, often directing and correcting even small details of their lives?

( ) 103. Do you feel you are not appreciated by those you care for?

( ) 104. Do you find yourself needing the attention and devotion of those you love, feeling it's their duty to stay in close contact with you?

( ) 105. When assessing people and situations, do you look for what you can find wrong?

( ) 106. Do the small habits and idiosyncrasies of others bother you?

( ) 107. Are you critical and intolerant of those who don't measure up to your standards or expectations?

( ) 108. Do you have strong opinions which you attempt to convince others are right?

( ) 109. Are you easily incensed by injustices, arguing for and defending principles which you believe in?

( ) 110. Are you high-strung, at times tense and over-enthusiastic, always teaching and philosophizing?

( ) 111. Do you feel you have a mission in life to conform with or live up to?

( ) 112. Are you strict in your adherence to a religious or social discipline, or in a particular way of living?

( ) 113. Do you feel it's important to make an example of yourself by living up to your ideals, so that others may follow?

( ) 114. Do you tend to take charge in circumstances and situations you're involved with?

( ) 115. Are you strong-willed and expect complete obedience (without question) from those around you?

( ) 116. Do you consider yourself a "born leader?"

ANSWER KEY Count the number of checks (for YES ANSWERS) in each of the given question groupings (example 1-3). If there are two or more Yes answers in a question group, put a check next to that Essence. Then refer to our catalog for a detailed description of each of the Essences you have checked. Select by priority the Essences you feel you need most. Remember up to six Essences may be combined and taken at one time. No more than six to eight. This questionnaire is meant for your personal confidential use and should be referred to when ordering. Please keep this completed questionnaire in your possession.

1-3 Aspen	4-6Mimulus	7-9 Cherry Plum
10-12 Red Chestnut	13-15 Rock Rose	16-18 Cerato
19-21Scleranthus	22-24 Wild Oat	25-27 Larch
28-30 Hornbeam	31-33 Clematis	34-36 Honeysuckle
37-39 Wild Rose	40-42White Chestnut	43-45 Chestnut Bud
46-48 Olive	49-51 Water Violet	52-54 Impatiens
55-57 Heather	58-60Agrimony	61-63Centaury
64-66Walnut	67-69Holly	70-72Pine
73-75Elm	76-78Star of Bethlehem	79-81Sweet Chestnut
82-84Gorse	85-87Mustard	88-90Gentian
91-93Oak	94-96Willow	97-101Crab Apple
102-104Chicory	105-107Beech	108-110Vervain
111-113Rock Water	114-116Vine	