Greetings!

And thank you for your interest in LivingWell Institute's lifestyle education programs and services. It is an honor to serve those in our community who are in search of something more to truly be well.

LivingWell Institute (LWI) is a community health nonprofit that provides a "Whole Person Health" approach to caring for people. Our mission is to empower people to take responsibility for their health and to be well in mind, body, and spirit.

Our approach is to create an environment that is full of respect, honor, and unconditional love where people feel safe to dig deep and heal from the inside out. Individual lifestyle education programs are created to integrate care for the whole person and help people learn how to live a life a balance, purpose, and passion.

These lifestyle education programs are not meant to replace existing clinical treatments. Instead, we integrate clinical care and lifestyle education to effectively utilize existing resources and maximize a person's ability to achieve optimal health and well-being. Our LivingWellCare team works in tandem with community care providers to ensure that each person receives the care needed to be well.

LWI is committed to providing whole person health care for our community regardless of an individual's ability to pay. Many of our programs are offered free of cost thanks to the generous support from the community, public, and private donations.

We invite you to come and experience LivingWellCare programs and services.

Sincerely,

The LivingWellCare Team

20 Valley Road
Hershey, PA 17033
(717) 533-0881
info@livingwellinstitute.net

Intake Form

Thank you for taking the time to complete the following intake form. Your honest feedback will help us help you. It will be our hope to support you in a journey to improved whole person health. If you are receiving health care service please inform your providers to insure appropriate care coordination. LivingWellCare is a lifestyle education program and should not replace or interfere with any other health or wellness services.

Name_____Birthdate_____Age_____ Sex: M / F

Address_____City_____State___Zip_____phone_____

Email_____ Marital Status (include number of marriages)_____

Occupation_____Employer_____Work phone_____

In case of emergency whom may we contact Name_____Telephone_____

What is your complaint? Explain symptoms:_____

_____

How long have you suffered? _____

Have you sought assistance for your problems? _____

What has been successful? What has not? _____

Now or in the past are you taking medications or in counseling for depression, anxiety or other emotional challenges (i.e. divorce,

Financial hardship, abuse, abandonment, or other tragic life experience)? _____

_____

Do you feel supported by family and friends? Please explain: _____

_____

I consider myself (circle one)	intellectual	social	unique	independent
My mind is often (circle one)	clear	busy	dreamy	confused or burdened

Do you consider yourself spiritual and/or religious? Please explain: _____

Religious Background? _____ How does this affect your life? _____

What gives you a sense of purpose? _____

How does your purpose influence your life? _____

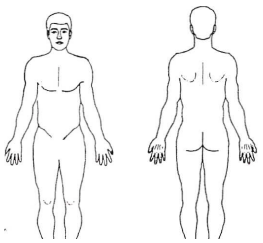
Do you have accessibility to a community or support system? Yes or No Explain: _____

I have experienced the following conditions. Please check all that apply:

☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Chronic Pain ☐ Addictions

☐ Surgeries: _____ ☐Medications: _____

☐ Other_____



Current complaint of pain 1-10 and what percent of the time? _____ **Where does it hurt?**

What resources have you utilized now or in the past for your health or wellness?

☐ Medicine ☐ Surgery ☐ Chiropractic ☐ Massage ☐ Acupuncture ☐ Homeopathy ☐ Spiritual Healing
☐ Psycho-therapy ☐ Biofeedback ☐ Counseling ☐ Hypnosis ☐ Chelation Therapy ☐ Support Groups

☐ Nutritional Therapy ☐ Exercise Program ☐ Other Resources _____

Do you feel balanced in your journey to find health? Yes or No How ready are you to make lifestyle changes? _____

Are you often too busy to take care of yourself properly? If so, what occupies your time? _____

What area(s) do you feel you need assistance? ☐ Physical ☐ Mental ☐ Spiritual What sacrifices are you willing to make to live well?

Glimpse … Who Am I

OVERVIEW

HOW ARE YOU?	1	2	3	4	5	6	7	8	9	10
	Dying and Disconnected				Fragmented but Functional				Healthy and Whole	

PHYSICAL

Pain*	1	2	3	4	5	6	7	8	9	10
	No Pain				Moderate Pain				Severe Pain	
Level of Function	1	2	3	4	5	6	7	8	9	10
	Completely Disabled				Disabled but Functional				Fully functional	
Available Resources	1	2	3	4	5	6	7	8	9	10
	No Resources				Some Resources				Unlimited Resources	

*Pain is the only question that needs to be reversed when calculated.

MENTAL

Attitude	1	2	3	4	5	6	7	8	9	10
	Poor				Average				Exceptional	
Thoughts	1	2	3	4	5	6	7	8	9	10
	Racing can't concentrate				Scattered but Functioning				Clear & Focused	
Intellect	1	2	3	4	5	6	7	8	9	10
	Uneducated				Average Intelligence				Highly Intellectual	

SPIRITUAL

I Feel Loved	1	2	3	4	5	6	7	8	9	10
	Never				Sometimes				Always	
I Feel Connected	1	2	3	4	5	6	7	8	9	10
	Never				Sometimes				Always	
I Feel Fulfilled	1	2	3	4	5	6	7	8	9	10
	Never				Sometimes				Always	

On the back of this page, please write a few sentences that describe your physical, mental and spiritual health.

30 Q: LivingWell Survey

How well are you? Please read the following statements and make an X as it applies to our life:

	Never	Rarely	Sometimes	Often	Always
1. I am well.					
2. I focus on the present moment.					
3. Faith is a part of my life.					
4. I consistently exercise good physical health.					
5. My life is balanced.					
6. My life is without guilt.					
7. I have meaning in my life.					
8. I am pain free.					
9. I do things that are good for me.					
10. I have hope for the future regardless of past failures.					
11. I find peace in nature and/or other creative expressions.					
12. I am interested in alternative healthcare options.					
13. I have healthy relationships.					
14. I replace negativity with positive thoughts.					
15. I participate in a spiritual or religious community.					
16. I sleep well.					
17. I make a positive contribution.					
18. I consider my opinions equally valid in comparison to others.					
19. I use music and/or art to lift my spirits.					
20. I am satisfied with my daily energy levels.					
21. I am content.					
22. I experience little anxiety and/or worry.					
23. I practice silence and solitude.					
24. I consume fruits and vegetables daily.					
25. I feel loved.					
26. I have good concentration and decision making skills.					
27. I am comfortable in social settings.					
28. My daily activities bring me joy.					
29. I am fearless.					
30. My life has little stress.					

Overall Health ____Good ____Fair ____Poor

Education ____High School/GED ____College ____Post-Graduate ____ NA

I think I will live to be _____years old Why_____

I have completed this intake to the best of my ability and permit this information to be used on my behalf as needed.

_____ _____

Signature **Date**

Note: Intake questions are for gathering information purposes only. Consult your healthcare provider for clinical advice.

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Lifestyle Education Services by LivingWell Institute

Authorization for Care

I hereby authorize LivingWell Institute to assist me in my journey towards better health. I understand that *LivingWellCare* services provided are not to replace my existing health care services and are for educational purposes only.

I agree that I am responsible for any pre-existing medically diagnosed condition and acknowledge my responsibility for all decisions made to modify any previous health care recommendations. At no time will recommendations be made by LivingWell Institute to discontinue medications or clinical interventions without advice from appropriate medical personnel.

Authorization for Release of Information

During your initial intake, LivingWell Institute will be evaluating your health from a spiritual, mental, and physical perspective. After this evaluation is complete, we will work together to develop a LivingWell Individual Life Plan (LWILP).

In order to better understand your spiritual, mental, and physical health history, we would like to request information from your other health care providers. It is our desire to work in cooperation with that person(s) to help you achieve your highest level of wellness. To do this we need your permission to share information related to your health history. If you are willing to grant this, please read carefully and sign the following statement.

I understand that LivingWell Institute, in order to provide optimal care, may request information from my primary care provider and any other care provider from whom I receive physical, mental, or social-spiritual care. I give my permission for this sharing of information.

_____

Printed Name of Participant/Family Representative Date

_____

Signature Name of Participant/Family Representative Date

(This release expires one year from the date signed.)

LivingWell Institute Release and Waiver of Liability

In an effort to better serve you, LivingWell Institute was created to support those in need of an integrative approach to health care. This coordinated effort provides you an opportunity to experience a more comprehensive approach to health care. It is the goal of LivingWell Institute to educate and empower clients to take responsibility for whole person health by coordinating clinical, wellness, and community services. The LivingWell Institute Team members are not medical professionals or licensed psychologists and are in no way meant to replace your existing healthcare providers. In consideration of participating in services and programs of LivingWell Institute, the undersigned participant/releaser named below agrees:

- There are potential risks (psychological, emotional, or physical injury) in participating in services and programs. I fully understand that there may be risks not known to us or that are not reasonably foreseeable to us at this time;
- I accept and assume such risks and responsibilities for the losses and/or damages following such psychological, emotional or physical injury and other risks to me and my family, however caused in whole or in part by LivingWell Institute, it's entity, staff, volunteers, and other organization representatives;
- The undersigned participant/releaser further expressly agrees that the foregoing release and waiver is intended to be as broad and inclusive as permitted by the law of the state in which the aforementioned LivingWell services and programs are being conducted, and that if any portion is held invalid, it is agreed that the balance of the release shall, notwithstanding, continue in full legal force and effect; and
- The undersigned participant/releaser grants LivingWell Institute permission to use photographs or video taken of the individual and family for the purpose of social media, promotion, and advertising by LivingWell Institute.

I have read this release and waiver of liability, assumption of risk and indemnity agreement, fully understand its terms, understand that I have given up substantial rights by signing it for myself and my family, and have signed it freely and voluntarily without inducement, assurance, or guarantee being made to me and my family, and intend my signature to be complete and unconditional release of all liability, including any negligence of the LivingWell Institute organization to the greatest extent allowed by law.

Printed Name of Participant/Family Representative:

_____

Signature of Participant /Family Representative:

_____

Date: _____

This release expires one year from the date signed.

LivingWellCare

Lifestyle Education Services by LivingWell Institute

Financial Responsibility

I understand that the *LivingWellCare* services provided by LivingWell Institute are considered to be wellness and are not reimbursable by third party payers. Due to the fact that *LivingWellCare* services are not reimbursable, I agree that I am financially responsible for the all costs of any services provided.

The fees for *LivingWellCare* services are as follows*:

- Individual Assessment: $150-$300
- Integration Services with Dr. Penny Koval: $200 per hour
- Integration Services with LivingWell Integrator: $150 per hour
- Care Coordination Services: $150 per hour
- Mentoring Services: $50 per hour
- 3D Balance Class: $15/class ($50/month)

*(*Services paid by credit card will include a merchant fee)*

I understand that I am financially responsible for all fees incurred for *LivingWellCare* services. Payment for *LivingWellCare* services is due in full at time of service.

_____

Client Name Printed Date

_____

Client Signature Date