



Moon Healing Studio

Thank you for your interest in Moon Healing Studio. We invite you to join us on a journey to a healthier body and a better quality life.

What our work has shown:

- Healthy people & people with great lives have bodies that are softer and more flexible than do people who are experiencing more illness or disease. Healthy people also breathe more.
- We do not have to be forceful, we can provide gentle care that creates long lasting results.
- No matter what else we do for ourselves (diet, exercise, drugs, meditation, etc.), our body and mind can function more effectively when there is less tension in our nervous system.

Enclosed you will find the following:

- Statement of Clinical Objectives **(Pages 2-3)**
- Practice Member Information Form **(Page 4)**
- Health History Form **(Pages 5-6)**
- Quality of Life Assessment **(Pages 7-8)**

Statement of Clinical Objectives

Our purpose in sharing this statement of clinical objectives is to clearly define our approach to health, healing and those we serve in this office. We wish to clearly communicate our responsibilities in this exciting relationship.

The following concepts are central to the way in which we care for others. We are pleased to share these ideas with you so our purpose can be in alignment from the very beginning.

There is an intelligence within each individual which not only keeps that person alive, but also coordinates, repairs, renews and heals every cell of the body.

The nervous system is the main distribution center and coordinating system for this intelligence. Proper coordination, repair, movement, healing and genetic potential can not be fully expressed when this life power and intelligence is suppressed.

The purpose of the entrainments given in this office are to train the nervous system, creating greater communication between your mind, body and life, thus promoting better health, vitality and sense of wellbeing. Everyone, in spite of specific symptoms or ailments, can benefit from more vitality & enhanced wellness.

Symptoms are not necessarily a sign of illness, they can occur to alert the individual of the need for change. This is central to how we care for others. If you want to become healthier and use your symptoms to motivate change in behavior, you are in the right place!

By their very intent, various treatments may interfere with the functioning of the nervous system. This may include drugs such as pain relievers, muscle relaxers, anti-inflammatory compounds and mood altering medication. This can often prolong the time required for advancement in care.

Medication levels may need to change, please have a good relationship with your medical doctor. We will not venture into the practice of medicine by advising about the need for reduction of medications. We suggest you speak with your physician to determine the objectives and goal to be obtained by receiving a particular medical treatment. Determine if this is consistent with your desire for wellness at this point in time. Your physician may guide you in changing any medication or treatments you are presently utilizing to accommodate for your changing body-mind.

Consistent with the above concepts, we train peoples' nervous systems and care for people using the techniques we believe to be the most honorable and effective.

Sincerely,

Melissa Moon | ELAN Healing Facilitator

I, _____ have read this statement of purpose and understand its contents. I understand that the care offered in this office is not a replacement for any form of treatment provided by other types of practitioners. I understand that I am not being treated for any condition or symptom. This office offers ELAN Healing Systems as a form of health and wellness care, to promote the natural mechanisms for self-healing and empowerment, as compared to specific target treatment.

Signature _____ Date _____ .

Practice Member Information

Name	
Date	
Address	
City	
Zip Code	
Phone (Home)	
Phone (Mobile)	
Email	
Referred By	
Date of Birth	
Age	
Height	
Weight	

Health History

1. Do you have any current health concerns? If so, please describe.

2. When did this situation or concern begin?

3. Have you ever been hospitalized? Yes No If yes, what was actually done to you?

4. Have you had surgery?

5. Do you still have all your body parts?

6. Have you consulted a physician or any other health care provider in the past three months? Yes No

7. What is/was the reason for the visit(s)?

8. What was done or suggested?

9. Please list drugs, when prescribed and reasons for taking them.

10. Do you have an exercise, meditation, prayer, nutritional or dietary program?

Yes/No Please explain:

11. Have you ever significantly injured your body? Yes/No

A) Date of most significant injury:

B) What happened?

C) Date of most recent injury?

D) What happened?

12. Have you broken any bones or significantly sprained part of your body? Yes/No

Please explain:

13. How much confidence do you have in your family MD 1-10? (10 is highest)

14. How much confidence do you have in your body's ability to heal itself, 1-10?

Quality of Life Assessment

15. To what age do you want to live?

16. How important is your health? 1-10

17. When stressed, how do you "center yourself" or "re-group"?

18. Is there some aspect of your life that very much pleases you, brings you joy, or helps you to feel better about yourself?

19. Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc. that you feel impair your opportunity for full glowing health?

20. Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook etc. that you feel give you an edge, or adds to your health?

21. How do you rate your physical health?

Excellent/Good/Fair/Poor/Getting Better/Getting Worse

22. How do you rate your emotional / mental health?

Excellent/Good/Fair/Poor/Getting Better/Getting Worse

23. If you consider yourself ill, why do you feel you are ill?

24. If you consider yourself well, why do you feel you are well?

25. What are some of your healthy sources of energy?

26. Where do you get energy that does not really serve you, or is actually unhealthy?

27. Where are you most irresponsible?

28. What are you addicted to? (Alcohol, sugar, adrenalin, etc.)

29. Why are you considering hiring us as your health advocate?

30. How will you know when your reasons or goals for being at this office have been met?

31. What consumes your time that does not give you a wonderful present or future?

32. Is there anything else you wish to share which may help us to better understand you or why you have chosen to be seen at Moon Healing Studio?

Quality of Life Survey

Directions - Tracking changes in a person's quality of life is the most important aspect of clinical assessment in your care. Please take the time to fill out this form completely and truthfully. Answer all questions from 0 - 10. If you feel the question does not apply, think about it again. Many men answer N/A to the question - incidence of menstrual discomfort, because they don't have a menstrual cycle. A better answer would be a 10 (never). Also, please total your score. Have fun!

I. Physical State

Rate the following questions on a frequency scale of 0 - 10

(0 = constantly 3 = regularly 5 = sometimes 8 = rarely & 10 = never)

1. Presence of physical pain (neck/back ache, sore arms/legs etc.).	
2. Feeling of tension, stiffness, or lack of flexibility in your spine.	
3. Incidence of fatigue or low energy.	
4. Incidence of colds and flu.	
5. Incidence of headaches (of any kind).	
6. Incidence of nausea or constipation.	
7. Incidence of menstrual discomfort.	
8. Incidence of allergies, eczema, or skin rashes.	
9. Incidence of dizziness or lightheadedness.	
10. Incidence of accidents, near accidents, or falling or tripping.	
TOTAL	

II. Mental/Emotional State

Rate the following questions on a frequency scale of 0 - 10

(0 = constantly 3 = regularly 5 =sometimes 8 = rarely & 10 = never)

1. If pain is present, how distressed are you about it?	
2. Presence of negative or critical feelings about yourself.	
3. Experience of moodiness, temper, or angry outbursts.	
4. Experience of depression or lack of interest.	
5. Being overly worried about small things.	
6. Difficulty thinking, concentrating, or indecisiveness.	
7. Experience of vague fears or anxiety.	
8. Being fidgety or restless; difficulty sitting still.	
9. Difficulty falling or staying asleep.	
10. Experience of recurring thoughts or dreams.	
TOTAL	

III. Stress Evaluation

Rate the following questions on a frequency scale of 0 - 10

(0 = extreme 2 = severe 4 = much 6 = some 8 = little 10 = none)

1. Family	
2. Significant Relationship	
3. Health	
4. Finances	
5. Sex Life	

6. Work	
7. School	
8. General well being	
9. Emotional well being	
10. Coping with daily problems	
TOTAL	

IV. Life Enjoyment

Rate the following questions on a frequency scale of 0 - 10

(0 = not at all 2 = rarely 5 = sometimes 8 = usually 10 = extensive)

1. Openness to guidance by your "inner voice/feelings."	
2. Experience of relaxation, ease, or well being.	
3. Interest in maintaining a healthy lifestyle (e.g., diet, fitness, etc.).	
4. Feeling of being open and aware/connected when relating to others.	
5. Level of confidence in your ability to deal with adversity.	
6. Level of compassion for, and acceptance of others.	
7. Satisfaction with the level of recreation in your life.	
8. Incidence of feelings of joy and/or happiness.	
9. Level of satisfaction with your sex life.	
10. Time devoted to things you enjoy.	
TOTAL	

V. Overall Quality of Life (Woodruff and Conway, 1992)

Rate the following questions on a frequency scale of 0 - 10

(0 = terrible 2 = unhappy 3 = mostly dissatisfied 5 = mixed 7 = mostly satisfied 8 = pleased 10 = delighted)

1. Your personal life.	
2. Your wife/husband or significant other.	
3. Your romantic life.	
4. Your job.	
5. Your co-workers.	
6. The actual work you do.	
7. Your handling of problems in your life.	
8. What you are actually accomplishing in your life.	
9. Your physical appearance – the way you look to others.	
10. Your self.	
11. The extent to which you can adjust to changes in your life.	
12. Your life as a whole.	
13. Overall contentment with your life.	
14. The extent to which your life has been what you wanted it to be.	
TOTAL	
GRAND TOTAL	

Are you becoming more compassionate and loving?	Yes / No
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