New members must agree to PMA membership terms and conditions before service.

MEMBER PROFILE

Full Name: _____ Date: _____

Date of birth _____ (MM/DD/YY) Sex: Male / Female

Full Address_____

Telephone: home_____ work:_____ mobile: _____

Email: _____ (Will be used to send summary reports.)

May we leave you phone text messages/call to confirm & cancel appointments? Yes No

Emergency contact: Name: _____

Phone number:_____ Relation_____

Who may we thank for referring you so we may discount their next scan : _____

HEALTH HISTORY

Please list your health concerns in order of importance.

Concern	Since (Year)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____

Have any of these issues changed or worsened over time, or increased with new drug or medication?

_____ _____

What effect have these issues had on your life? _____

Do you know your blood type, and if so, please include? _____

Please list forms of treatment that you have used and describe their effectiveness

_____

_____

How do you describe your general state of health? Please circle or make highlight: Excellent Good Fair Poor

Have you had routine screenings, and if so, how often/date of last?

Mammograms_____ PAP _____ Hormone Levels_____

Prostate screenings/PSA _____ AMAS _____ Thermography _____

Colonoscopies_____ CBC _____ 25-Hydroxy Vitamin D Blood Test _____

PET Scan _____ CT Scan _____ MRI_____ HCG_____

D-Dimer (monitors blood clotting) _____ Other Testing:_____ _____

Vaccinations (date those that apply): Childhood Shots: _____

Do you receive annual influenza vaccines? _____ When was your last influenza vaccine? _____

Have you received Covid-19 vaccine?_____ Which brand and date of last serum injection:_____

Other vaccinations (i.e. shingles, meningitis, etc.):_____

Please describe reactions if applicable: _____

Dental exams_____ Fillings: _____ (amalgam-silver, or resin?) **Root Canals**_____

Describe Your Dental Hygiene Care: _____Fluoride Toothpaste?_____

In the last five years, how many courses of antibiotics have you taken? _____

When was the most recent course of antibiotics? _____

Have you had implants and/or transplants? If so, please identify: _____

Elimination. Do you have DAILY regular bowel movements? # per day _____ If not, # per week _____

Do you currently use vitamins and supplements, and if so, please list:

	BRAND/NAME	Milligrams or units per day
Multi Vitamin: powder/capsule		
Omega 3: Fish or Vegan		
Probiotic and/or Prebiotic		
Vitamin D3 – does it have K2		
Vitamin C		
Digestive Enzymes		
Other		

Please indicate if whole food supplement.

Do you use essential oils regularly? _____ Brands: _____

Have you ever experienced the following, if so please circle and also indicate if it was helpful with 1 indicating "made little difference" and 5 indicating "marked improvement":

Acupuncture 1 2 3 4 5

Acupressure 1 2 3 4 5

Massage/Type 1 2 3 4 5

Chiropractic 1 2 3 4 5

Myofascial Release 1 2 3 4 5

Cranial Sacral 1 2 3 4 5

Laser Therapy 1 2 3 4 5

Reflexology 1 2 3 4 5

Aromatherapy 1 2 3 4 5

Psychology 1 2 3 4 5

Emotional Release Therapy 1 2 3 4 5

IV Therapy 1 2 3 4 5

- Type of IV _____

Other_____ 1 2 3 4 5

MEDICATIONS / DRUGS

Please list all current medications you take including prescription drugs, *over the counter drugs, acid blockers, etc.*

Drug/ Supplement	Used For	Date Started	Dosage

Which of the following have you used/ do you currently use? Please include amount, frequency, and duration of use.

Tobacco /Vaping _____
Anti-acids _____
Ibuprofen or acetaminophen_____
Sedatives_____
Steroids _____ (including injections)
Cortisone (including topical cream) _____
CBD/Brand: _____

Recreational Drugs _____

Other? _____

KNOWN ALLERGIES, SENSITIVITIES

Please list any known or suspected allergies, sensitivities and/ or intolerances.

Drugs	Food	Environmental/Chemical

LIFESTYLE / ENVIRONMENT / EMF EXPOSURE

What is your occupation? _____ Do you work from home?_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____

_____

How many hours a day do you sit in front of a computer?_____ Are you mindful to stretch?_____

Do you use your cell phone on speaker mode or placed to your ear? _____

Where do you carry your cellphone? _____

Are you using your cell phone on Wi-Fi mode while sleeping? _____

Is your home set up for wireless communications (Wi-Fi)?_____ 5G? _____

Does your home have a radon detector/monitor system? _____/_____

Do you use AI in your home, such as Siri or Alexis?_____

Is your home located within a mile of a cell tower? _____, or a wind turbine? _____

Is your home equipped with Smart Meter by your utility company? _____ Are beds on Smart Meter walls _____

Smart meters have digital numbers and stick out about 3 inches from the home vs. the meter with analog numbers, which sticks out approximately one inch. If you do not have a "meter man" coming to read the meter, you have a Smart Meter.

What type of mattress do you sleep on? Coil/Foam combo Memory Foam Waterbed Latex Other_____

What kind of water do you drink: _____ Number of 8 oz glasses per day? _____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

_____

_____

_____

SYMPTOMS & PAIN SIGNALS

Please circle any symptoms and signals below that apply to your current situation:

Acid reflux/GERD
Anxiety
Asthma
Auto Immune _____
Bruise Easily
Bulged Discs
Cancer/Type _____
Candida/Fungal (white tongue)
Chronic Fatigue
Chronic Sinusitis
Circulation Issues
Depression
Eczema / TSW
Fibromyalgia
Foggy Thinking
Headaches
Heart Condition
____Pericarditis
____ Myocarditis
High Blood Pressure
High Cholesterol
Hip or knee pain
Irregular Heart Beat
Low back pain
Lyme Diagnosis
Migraines
Neck pain
Neuralgia (numbness)
Night Sweats/Hot Flashes
Overweight
Parasites
PMS / PCOS
Rash location _____
Seizures
Tendonitis
Tingling Sensations
Tinnitus
Tooth Infection
Type 1 Diabetes
Type 2 Diabetes
Unexpected Weight Loss
Other _____

How is your diet:

- Coffee: _____ cups per □ day □week □ month *Is coffee organic?* Yes or No
- Soda: _____ cans per □ day □week □ month ____Diet ____ Regular
- Candy: _____ times per □ day □week □ month
- Chocolate: _____ times per □ day □week □ month Is chocolate organic? Yes or No
- Alcohol: _____ times per □ day □week □ month Type: _____
- Fast Food: _____ times per □ day □week □ month
- Dairy: _____ times per □ day □week □ month ____Milk ____ Cheese ____ Yogurt
- Margarine or tub spreads: _____ times per □ day □week □ month
- Fried Foods: _____ times per □ day □week □ month
- Salad dressing (store bought): _____ servings per □ day □week □ month
- Vegetables _____ servings per □ day

Current Diet Information: Please give examples of foods you typically eat AND the time of day.

Breakfast: _____

Lunch: _____

Snacks: _____Do you snack after 7 pm?_____

Dinner: _____

Liquids:

_____

Fats (please list types of oils used and other fat sources) _____

How many meals do you eat per day? _____ What meals do you skip? _____

Do you cook? _____ What percentage of meals are home-cooked? _____

What kind of cookware are you using? Circle: Non-Stick (Teflon) Stainless Steel Aluminum Ceramic Enamel Coated Glass Cast Iron. *Bakeware*: Non-stick Ceramic Silicone Other: _____

Is there anything that you feel is important that has not been covered?

_____

Commitment Level – How serious are you about improving your health?

□ Very serious □ Serious Other _____

What are you willing to do to improve your health?

□ Take supplements only □ Exercise Only □ Make diet changes □ Whatever it takes!!!!

Please note that Purely Living Wellness operates Mondays-Thursdays between 9am to 5 pm. DNA may be collected and mailed to facilitate bio-energetic scans, and is equally as effective and accurate as a physical visit to our wellness center. We especially recommend DNA remote scans during the winter season due to the rural location of our facilities. Comprehensive Wellness Scans average **2 hrs.** and remote testing is recommended for most.

Post-scan consultations are 15 minutes, after which consultation will be charged in 15 minute intervals at $20 per quarter hour. Bio-energetic scan summaries will be provided 48-72 hours after scheduled scan, weekdays via e-mail.

After reviewing your scan reports please provide questions via email, and/or schedule your 15 minute follow-up by phone. All forms of communication will be monitored for time.
All questions asked during non-operating hours will be addressed during business hours. If you would like to reference responses to your questions, e-mail should be used. **Consultation time will be invoiced accordingly**.

FOLLOW UP TREATMENTS:

The Qest 4 system may indicate follow up therapies. These holistic modalities and referrals may be suggested individually or in combination to qualified practitioners to address your health condition(s), which may include:

- Naturopathic Medical Doctor
- Botanical/Herbal Supplements
- Transfer Factor Molecule Immunotherapy
- Liquid Mineral and Vitamin Supplements
- Homeopathic Remedies
- Acupuncture or Acupressure
- Reflexology
- Psychotherapy/ Counseling
- Chelation Treatment
- Colon Hydrotherapy & Enemas
- Massage
- Rolfing
- PEMF
- Bio-Mat Therapy
- Grounding Therapy
- Infrared Sauna
- Magnesium Floats
- Aromatherapy/Essential Oils
- Access Bars
- Ionic Foot Bath
- Personal Cooking Chef
- Chiropractic Care

Although the above treatments are safe and natural, even the gentlest therapies can have complications and/or "healing efforts" that accompany natural detoxification of the body. This is especially true in certain conditions such as pregnancy, lactation, or in very young children. **We need to know if you are pregnant, suspect you are pregnant, are attempting to become pregnant**; or if you are breastfeeding. (Bio-energetics protocols are available for pregnancy and post-partum.)

Some complications that can occur with holistic treatment, including bio-energetics. Examples are, but are not limited to:

- Aggravation of pre-existing or existing symptoms (may become worse before improvement)
  This is often referred to as a detox, or Herxheimer, reaction. Headache, nausea, stomach pains, fatigue.
  Often an herbal drainer may be recommended to ease and reduce this effect, as well as drinking water.
- Allergic reactions (for example to suggested supplements or herbs, of which the client decides to use, or not)

I understand that the results are not guaranteed. I do not expect Rita Shimniok to be able to anticipate or explain all risks and complications. I accept all responsibility for my health and wellness choices as is my right, and have agreed to the PMA rules of membership.

Rita Shimniok's consultations are limited to providing self-help education and guidance in natural health matters, nutrition, food supplements, spiritual connection, natural remedies, and the advocating of a healthy lifestyle. As a member of High Vibration Life Ministries I will be adhere to the association terms and conditions. I will be proactive and utilize education / resources provided by Rita Shimniok, Purely Living – including website information, to learn how to take better care of my own body so that it may work itself towards rebalancing and optimal wellness.

Member Name (Please Print): _____

Member Signature*: _____ Date Signed:_____
*Parent/Legal Guardian to sign if younger than 18 years old.

How did you learn about Purely Living Wellness _____
We reward referrals from members with a $20 gift certificate to be used on their next bio-energetic scan session.

It is important, after your session, to drink plenty of filtered water throughout the remainder of the day. Please avoid tap water with fluoride and chlorine. **Please initial that you understand importance of drinking water. _____**