

NEW CLIENT PACKET

Fill out and return to staff

Terms of Acceptance

Cancellation Policy

Prescription Drug and Supplementation Form

Agreement for Attunements

Medical History Questionnaire

Personality Questionnaire

Prescription Drug and Supplementation Form

Implementation and Assessment Form

Client Attunement Plan

Cancellation Policy



TERMS OF ACCEPTANCE

For Nicole VanderMeyden & Attunement Services

This document constitutes informed consent for services provided by Nicole M. VanderMeyden.

When a client seeks my services and I accept that client, it is essential that we interact within the same framework to prevent confusion and disappointment, and to maximize efficiency and effectiveness. To that end, I offer the following.

Thank you.

A *dissonant bioprogram* is a stored memory constellation which elicits disadvantageous physiological responses. In my experience most acute and chronic pain, stress, and other unwanted symptoms are both initiated and maintained by dissonant bioprograms. Subtle-influence medicine (SIM), a tradition of healing which began being taught in Paris, France in 1783, aims to artificially adapt dissonant bioprograms into resonant ones. This is known as an *attunement*. SIM achieves attunements utilizing the natural mechanisms underlying the processing of incoming stimuli and the accessing of stored memories.

I do not offer to diagnose, treat, or cure any disease or condition, whether physical, mental, or emotional other than dissonant bioprograms. I do not offer to prescribe any medication. I do not offer therapy in any form. **I offer to solely address the pertinent dissonant bioprograms which interfere with the full expression of ease, vitality, and peace.** This is accomplished through conversations and directed contact.

All services are non-therapeutic and therefore do not include any elements which would require the maintenance of any medical license.

By signing below, you accept the responsibility to keep me informed and updated regarding any accidents, injuries, surgeries, illnesses, medications, or other factors that could relate to the safeness and effectiveness of receiving the services described above. You also affirm that you have read the preceding paragraphs and that all questions pertaining to receiving services subject to the above-described conditions have been answered to your satisfaction prior to placing my signature below. And that you additionally accept those conditions and affirm your intent to work with me as I have outlined above.

Full Legal Name _____

DOB ____/____/____

Signature (actual) _____

Date ____/____/____

Complete if client is a minor or declared mentally incompetent.

I, being the parent or legal guardian of the individual listed below, have read, had any questions I had answered to my satisfaction, and signed the above "terms of acceptance." I hereby grant permission for the following individual to receive services as described above by Nicole VanderMeyden.

Minor's Full Legal Name _____

DOB ____/____/____

Signature (actual) _____

Date ____/____/____



Drug Awareness Disclosure Form

I, _____, acknowledge that any and all information, advice and/or feedback regarding prescription medications I receive from Nicole Vandermeiden and any of it's affiliated practitioners and physicians is for informational purposes only. I acknowledge that it is not a specific recommendation to alter the dosage, stop altogether, or begin any prescription medication whatsoever.

By signing this I have acknowledged that I am solely responsible for any alterations I make in my medications. I also realize that it is my responsibility to coordinate any such changes with the prescribing physicians, pharmacists or any others in order to safely and properly do so.

Date _____

Signature _____

ATTUNEMENT AGREEMENT

Understand the expectation as the client prior to your first attunement session, please initial each individual statement.

___ I understand if an issue with the practitioner recommendation arises, I will not discontinue any recommendations. I will reach out to the practitioner immediately.

___ I understand anytime a recommendation is discontinued without permission, it delays care and is considered non-compliant. (water, supplements, CEP, etc.)

___ I understand if I am non-compliant for three consecutive sessions, care will be discontinued.

___ Cancellation policy requires 24 hours' notice or you will be charged in full and must be paid prior to scheduling any further attunement sessions.

___ I understand I must give 4 hours' notice to move an in person session to a remote session.

___ Technical difficulties / remote session Policy.

___ I have read ALL the reading material listed under "Required Reading" prior to my consultation.

___ I am aware of all the required purchases prior to my first attunement and will have them readily available.

___ Financial Policy regarding packages and payment (return policy etc)

___ I understand and have signed the terms of acceptance form.

___ Based off the required reading and expectations I will bring up any questions during my consultation.

___ I am aware of my required water intake and agree to have completed 7 consecutive days prior to my first attunement session.

___ I am aware of Core Essence Protection process and agree to do it 2x a day for 7 consecutive days prior to my first attunement session.

___ I have read the Autonomic Recovery Program and will be prepared to start this program my first attunement session.

Signature _____ Date _____

Client expectation prior to first attunement

Required:

Drink your water: Take your current body weight and multiply it by 0.66, this will give you the number of ounces you are required to drink for 7 consecutive days prior to your first attunement. If you are having physical difficulty drinking your water (nausea, gagging) notify me immediately. Be prepared, you will need to plan ahead. Review document Hydration Policies and Pointers. Choose your container and USE the same container. Required to bring their container to every visit with them to take supplements, to do testing, salt taste test, *have your water with you for attunement appointment* (pg #).

Core Essence Protection: Complete core essence protection at morning and in the night, with stoking the fire once throughout the day. Do not deviate from the protection mediation or alter it in anyway. Record yourself reading the instructions aloud or watch the YouTube videos listed below until you are familiar enough with the instructions.

(pg #)

<https://www.youtube.com/watch?v=S3UvDM3JZ-o>

<https://www.youtube.com/watch?v=it3DBegSe0w>

Purchases: Review the purchases required, it includes supplements, food items, TBM materials. Find those items near you and have them in your home by your first attunement session.

Have client Attunement kit in home by first attunement. (See page #)

Practice Improving:

Sleep Hygiene: Take note of your current sleep hygiene habits and work to make changes this week. Get creative with solutions, black out windows, tape lights, move electronics, (see page #)

Electromagnetic Hygiene: Work toward not putting your cell phone on your body or up to your head, less time with blue tooth headphones, no laptops directly on body. Studies show electro-magnetics negatively impact our physiology. (see page #)

Practice ARP: Review the autonomic recovery program sheet. Start working to implement the changes through your diet, purchase foods required to have on hand liver, steak, offal etc. Avoid sweeteners, work to read labels, plan out your meals. (see page #)

Regulating Circadian rhythm: Circadian Rhythm is a natural 24 hour cycle. It includes physical, mental, and behavioral changes. Take note of your current circadian patterns, work throughout the week to finalize your circadian worksheet (see pages #-#)

Wearing your violet wrist bands: Wear these wristbands 24/7. These are essential to your health improvement.

Flying protection

<https://www.youtube.com/watch?v=m2uTHzzXT98>

Medical History Questionnaire

Name: _____	Age: _____	Date of Visit: / /
Height: Feet	Inches	Weight: pounds

Medical Illnesses

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> COPD/
Emphysema | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Migraine | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Acid Reflux/
Ulcers | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cancer (Specify)
_____ | | <input type="checkbox"/> MRSA |

Surgical History

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Tonsils removed | <input type="checkbox"/> Cataract surgery |
| <input type="checkbox"/> Cardiac Stent Placement | <input type="checkbox"/> Shoulder Surgery | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Bowel Surgery | |
| <input type="checkbox"/> Gall Bladder removed | <input type="checkbox"/> Appendix removed | |

<u>Surgeries:</u>	<u>Surgeon:</u>	<u>Date:</u>	<u>Outcome:</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Family History

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Spine Disorder |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | |
| | <input type="checkbox"/> Blood Clots | |

Personal History

- | | | |
|------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Single | <input type="checkbox"/> Student | <input type="checkbox"/> Number of Children: _____ |
| <input type="checkbox"/> Married | <input type="checkbox"/> Unemployed | |
| <input type="checkbox"/> Divorces | <input type="checkbox"/> Disabled | <input type="checkbox"/> Number of Children at Home: _____ |
| <input type="checkbox"/> Separated | <input type="checkbox"/> Retired | |
| <input type="checkbox"/> Widowed | | |
| <input type="checkbox"/> Employed | | |

Pregnant: Yes No

Social History: Please indicate how often you use the following Substances

Tobacco:

- Never Smoked
- Smoke __ pack(s) of cigarettes/day OR Chew 1 can every __ day(s)

Medical History Questionnaire

Alcohol:

- Never Rarely Moderately (3-5 days/week) Daily

Recreational Drugs:

- Never Rarely Moderately (3-5 days/week) Daily

What Medications do you take? (Please list all medications and dosages. Include over the counter medications and herbal supplements)

_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medication? (Please list medication and reaction)

_____	_____
_____	_____

Mark Only Symptoms you have had in the last 3 months:

GENERAL:

- Fatigue
- Fever
- Night Pain
- Weight Gain
- Unexplained Weight Loss

GASTROINTESTINAL

- Abdominal Pain
- Constipation
- Diarrhea
- Frequent Heartburn

EARS, NOSE, THROAT

- Hearing Loss
- Ringing in the ears
- Vertigo
- Nasal congestion
- Mouth/lip sores
- Tooth abscess
- Difficulty Swallowing
- Hoarse voice
- Throat lesions

NEUROLOGICAL

- Difficulty with balance
- Loss of coordination
- Gait abnormality
- Headaches
- Muscle weakness
- Seizures
- Sensory disturbance
- Speech difficulty
- Tremor

GENITOURINARY

- Erectile dysfunction
- Increased urination
- Decreased urination
- Loss of urine
- Burning/pain with urination

BLOOD/ LYMPHATIC:

- Bleed easily
- Prolonged bleeding after surgery
- Bruise Easily
- Painful/ swollen lymph node (s)

CARDIAC

- Chest Pain
- Shortness of breath w/activity
- Lower extremity swelling
- Heart Murmur
- Heart racing

PSYCHIATRIC

- Depression
- Anxiety

ALLERGY/IMMUNE

- Immune Disorder
- Seasonal allergies

RESPIRATORY

- Cough
- Vomiting blood
- Shortness of Breath
- Wheezing

EYES

- Discharge
- Cataracts
- Visual field loss

SKIN

- Abnormal growth
- Rash
- Non-healing sore

Do you have any current addictions? _____

The Information provided in the form is true and complete to the best of my knowledge:

Signature _____

Personality Test

Name:

Date:

Age:

Statements

<input type="checkbox"/> I have a natural talent for influencing people.	<input type="checkbox"/> I am not good at influencing people.
<input type="checkbox"/> Modesty doesn't become me.	<input type="checkbox"/> I am essentially a modest person.
<input type="checkbox"/> I would do almost anything on a dare.	<input type="checkbox"/> I tend to be a fairly cautious person.
<input type="checkbox"/> I know that I am good because everybody keeps telling me so.	<input type="checkbox"/> When people compliment me I sometimes get embarrassed.
<input type="checkbox"/> If I ruled the world it would be a better place.	<input type="checkbox"/> The thought of ruling the world frightens the hell out of me.
<input type="checkbox"/> I can usually talk my way out of anything.	<input type="checkbox"/> I try to accept the consequences of my behavior.
<input type="checkbox"/> I like to be the center of attention.	<input type="checkbox"/> I prefer to blend in with the crowd.
<input type="checkbox"/> I will be a success.	<input type="checkbox"/> I am not too concerned about success.

<input type="checkbox"/> I think I am a special person.	<input type="checkbox"/> I am no better or worse than most people.
<input type="checkbox"/> I see myself as a good leader.	<input type="checkbox"/> I am not sure if I would make a good leader.
<input type="checkbox"/> I am assertive.	<input type="checkbox"/> I wish I were more assertive.
<input type="checkbox"/> I like to have authority over other people.	<input type="checkbox"/> I don't mind following orders.
<input type="checkbox"/> I find it easy to manipulate people.	<input type="checkbox"/> I don't like it when I find myself manipulating people.
<input type="checkbox"/> I insist upon getting the respect that is due me.	<input type="checkbox"/> I usually get the respect that I deserve.
<input type="checkbox"/> I like to show off my body.	<input type="checkbox"/> I don't particularly like to show off my body.
<input type="checkbox"/> I can read people like a book.	<input type="checkbox"/> People are sometimes hard to understand.
<input type="checkbox"/> I like to take responsibility for making decisions.	<input type="checkbox"/> If I feel competent I am willing to take responsibility for making decisions.
<input type="checkbox"/> I want to amount to something in the eyes of the world.	<input type="checkbox"/> I just want to be reasonably happy.
<input type="checkbox"/> I like to look at my body.	<input type="checkbox"/> My body is nothing special.
<input type="checkbox"/> I will usually show off if I get the chance.	<input type="checkbox"/> I try not to be a show off.
<input type="checkbox"/> I always know what I am doing.	<input type="checkbox"/> Sometimes, I am not sure of what I am doing.

<input type="checkbox"/> I rarely depend on anyone else to get things done.	<input type="checkbox"/> I sometimes depend on people to get things done.
<input type="checkbox"/> Everybody likes to hear my stories.	<input type="checkbox"/> Sometimes I tell good stories.
<input type="checkbox"/> I expect a great deal from other people.	<input type="checkbox"/> I like to do things for other people.
<input type="checkbox"/> I will never be satisfied until I get all that I deserve.	<input type="checkbox"/> I take my satisfactions as they come.
<input type="checkbox"/> I like to be complimented.	<input type="checkbox"/> Compliments embarrass me.
<input type="checkbox"/> I have a strong will to power.	<input type="checkbox"/> Power for its own sake doesn't interest me.
<input type="checkbox"/> I like to start new fads and fashions.	<input type="checkbox"/> I don't care about new fads and fashions.
<input type="checkbox"/> I like to look at myself in the mirror.	<input type="checkbox"/> I am not particularly interested in looking at myself in the mirror.
<input type="checkbox"/> I really like to be the center of attention.	<input type="checkbox"/> It makes me uncomfortable to be the center of attention.
<input type="checkbox"/> I can live my life in any way I want to.	<input type="checkbox"/> People can't always live their lives in terms of what they want.
<input type="checkbox"/> People always seem to recognize my authority.	<input type="checkbox"/> Being an authority doesn't mean that much to me.
<input type="checkbox"/> I would prefer to be a leader.	<input type="checkbox"/> It makes little difference to me whether I am a leader or not.
<input type="checkbox"/> I am going to be a great person.	<input type="checkbox"/> I hope I am going to be successful.

<input type="checkbox"/> I can make anybody believe anything I want them to.	<input type="checkbox"/> People sometimes believe what I tell them.
<input type="checkbox"/> I am a born leader.	<input type="checkbox"/> Leadership is a quality that takes a long time to develop.
<input type="checkbox"/> I wish somebody would someday write my biography.	<input type="checkbox"/> I don't like people to pry into my life for any reason.
<input type="checkbox"/> I get upset when people don't notice how I look when I go out in public.	<input type="checkbox"/> I don't mind blending into the crowd when I go out in public.
<input type="checkbox"/> I am more capable than other people.	<input type="checkbox"/> There is a lot that I can learn from other people.
<input type="checkbox"/> I am an extraordinary person.	<input type="checkbox"/> I am much like everybody else.
Total in this column:	Total in this column:

Reflection

Please share any thoughts, feelings, or experiences that arose while completing this test. Are there areas where you'd like to explore or discuss further?

What I'd like you to know about drugs

It's not a secret that I, Dr. Kevin S. Millet, am not a fan of medications. I haven't used any for over 20 years, surgery on my broken ankle excepted. I believe, and there's A LOT of data to back this up, that we would actually be better off if there were NO drugs prescribed in America. That being said, there are three instances where I believe pharmacological intervention is warranted.

The first instance is to buy time. When a person may die, cause injury to others or suffer some permanent damage before a natural healing regimen could run its course, pharmacological and/or surgical intervention is a good idea. One example was when my oldest daughter was diagnosed with leukemia, life-saving antibiotics and chemotherapy were needed to keep her alive until we could address the reason she got sick and support her body to a full recovery.

The second instance is to replace a permanently lost function. When a part of the body has been removed or damaged to the point where it can no longer function, replacing the function makes sense. An example of this would be an individual who had hyperthyroidism and had the thyroid destroyed by irradiation. In this instance, thyroid hormone replacement therapy would be required.

The third instance is to enable a necessary medical procedure. An example of this would be anesthesia for a surgery.

You might wonder if I'm really serious, if I really think that drugs should be restricted to those three exceptions? The answer is yes, I'm dead serious. For three reasons, all medications are dangerous, drug-free healing is available and effective, and symptoms are part of the healing process.

Let me say a word or two about symptoms and the healing process. The body is completely capable of suppressing any process that is causing a symptom like pain, nausea, fatigue, etc... Your body, however, is choosing to have the symptom because it is aiding the healing process. An example of this is a fever. Fevers accelerate the destruction of infectious organisms. Any time symptoms are masked, recovery is delayed, more fibrosis (scarring) occurs, and an opportunity to have suffering result in a renewed commitment to taking better care of the body is missed. Additionally, symptoms guide you and your health care provider in understanding what's wrong and knowing if the therapy provided is working.

Earlier I talked about there being data to support my assertion that even though drugs help in several instances, overall we'd be better off without them. Well here are a few things to consider:

- The average American fills 12 prescriptions each year.²
- For every dollar spent on a drug, a \$1.33 is spent to address adverse drug reactions (ADRs).³
- 1 out of every 5 people admitted to a hospital have to be treated for a drug-related problem (DRPs) caused by a drug they received during their hospital stay.³
- Every day more than 4,000 patients have ADRs that land them in an American hospital.³
- More than 1 in 4 people admitted to a hospital are there because of a DRPs.⁴
- ADRs kill more than 200,000 Americans each year, the same number of deaths as 9/11 every week.⁴
- Most ADRs occur when the right drug is given to the right patient at the right time in the right doses.⁵
- Almost half of the deaths from adverse drug reactions and 61% of hospitalizations from adverse drug reactions are in people younger than 60.⁶

A personal example of the above statistics is my father. He took ibuprofen for knee pain, developed an ulcer from the medication, was admitted to the hospital for treatment of the ulcer and had to take more drugs to treat the ulcer. In other words, the pharmaceutical approach causes its customers to use more of their products in order to survive the effects of the first! I'm suggesting we find a safer option as often as possible.

Information on the web: www.drugawareness.org, www.worstpills.org.

1. Annual cost of Rx Therapy problems placed at \$77 billion – *Drug Topics*, OCT 23, 1995

2. Ukens C. How mail order pharmacy gained in market share in 2003. *Drug Topics* Mar 22, 2004; 148.

3. Drug-related problems pose worsening 'silent disease' - *Drug Topics*, MAY 3 1999

4. Arch of Internal Med, Oct 9, 1995 Johnson & Bootman

5. Is standard dosing to blame for adverse drug reactions?, *Drug Topics* JAN 17, 2000

6. Food and Drug Administration. Second Annual Adverse Drug/Biologic Reaction Report: 1986, 1987.

NOTE: The above information is for educational purposes and should not be construed as personal medical advice.

**“There is no
risk-free drug
therapy.”¹**

John Gans,
American Pharmaceutical Association Executive
Vice-president

Autonomic Recovery and Implementation Assessment



Name _____ DOB _____ Date _____

This Compliance Assessment form is designed to support you in developing habits and practices that support your healing and ongoing well being. This form is tailored to those of Western European heritage and may need to be customized for you if you have a different lineage.

Answer the questions honestly. Circle a number for each statement with "0" representing **completely false** and "10" **completely true**. The first two questions apply to clinical progress. Do not include those totals with the questions that follow. If a question does not apply, place an "X" on the number 10 and count it as a 10 in your calculations. Starred (*) questions apply only to those who have passed their Challenge Meal. Upon completion, calculate totals and write in the provided locations.

NOTE: We recognize that some individuals may not consider the following guidelines as "politically correct" nutrition. Rest assured, however, that they have been drawn from traditional practices and utilized, with great success, by experienced TBM providers for decades. Please discuss any considerations you have with your TBM provider.

Since my last TBM appointment...

SLEEP...I have fallen asleep within 15 minutes and woken up 7-9 hours later, in the same position, feeling refreshed.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

BOWEL MOVEMENTS...I had a properly formed (one continuous stool, tapered both ends, caramel color, no invaginations, no visible food particles) bowel movement, that did not require straining, following each meal.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

AUTONOMIC RECOVERY TOTAL _____/20

WATER...I drank no less than 2/3 of an ounce of water per pound of my body weight (43.5mL/Kg) and no more than 32 ounces (1L) above that each day.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

BLUE BEEF...I have eaten a beef steak prepared "blue" or steak tartare at least once per week.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

LIVER...I have eaten beef liver at least once per week.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

OFFAL...I have eaten offal (e.g. heart, kidney, sweet bread, tendon, marrow) at least once every other week.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

LIQUID FOOD...Excepting soups and red wine, I have avoided all liquid foods (milks of all kinds, juices, nutritional shakes, smoothies), unless otherwise directed. When otherwise directed, I am sipping and thoroughly mixing with saliva before swallowing.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

IMPLEMENTATION TOTAL 1 _____/50

Name _____ DOB _____ Date _____

CHEWING...I have chewed all food consumed to the point of liquid before swallowing.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

SWEETENERS...I have avoided all sweeteners other than cane sugar and organic corn syrup.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

SUPPLEMENTS...I have taken all of my supplements as advised (includes Autonomic Recovery Meal, if directed).

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

DISINFECT...I have applied to my skin or douched with a disinfectant, as recommended by my TBM provider.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

DAIRY...I have consumed dairy products (e.g. cheese, yogurt, kefir, butter, cream) on a daily basis.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

OMNIVORE...I have not avoided any food categories (e.g. gluten containing grains, dairy, animal products) that I have not been recommended to avoid by my TBM provider.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

SALT...I have conscientiously salted to taste.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

PRE-CHALLENGE MEAL...I have fully complied with the dietary guidelines of the Autonomic Recovery Program (ARP).

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

POST-CHALLENGE MEAL...I have carefully listened to, and complied with, my body while I have expanded my food choices beyond those allowed in the ARP.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

GRAINS, LEGUMES*... I have only consumed grains and legumes that have been germinated (sprouted) and/or fermented AND cooked, excepting "al dente" (firm center) pasta and rice which has been dry or oil cooked prior to water cooking.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

RED WINE*...I have consumed some red wine at least once per week.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

INSOLUABLE FIBER...I have consumed food stuffs that contained insoluble fiber (e.g. greens, veggies, fruit, whole grains, legumes) with each meal.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

BOWEL HABITS...Within 30 minutes of finishing a meal I have taken up to 10 minutes on the toilet, if necessary, to allow my body to have a bowel movement.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

IMPLEMENTATION TOTAL 2 _____/130

Name _____ DOB _____ Date _____

TREATS/DESSERTS*...I have allowed myself to enjoy high-quality desserts and other treats in a way that respects my body's limits.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

PHYSICAL ACTIVITY...I have averaged an hour or more of physical activity a day.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

ISOLATION BANDS...I have worn violet Isolation Bands as directed by my provider.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

PROTECTION...I have practiced Protection a minimum of each morning and each evening.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

CIRCADIAN...I have retired to bed and arisen from bed at the same time each day.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

SLEEP HYGIENE...I have slept in a quiet, completely dark room, with no operating electronics within 5 feet.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

MOBILE DEVICE...Other than in my hand, I have not placed any mobile device (e.g. smartphone) against my body, my head or in my pocket, while the device is turned on (excepting "airplane" mode).

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

POSTURE...I have maintained an ongoing level of conscientiousness regarding the guidance I've been given about optimal posture throughout my daily activities.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

CORE TRUTH INFUSION...I have infused my "Spark of Life" with my Core Truth during each Protection practice.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

CORE TRUTH REPATTERNING...I have conscientiously engaged in the practices, language and behaviors, recommended to me by my provider, that support repatterning of my life around my Core Truth.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

IMPLEMENTATION TOTAL 3 _____/100

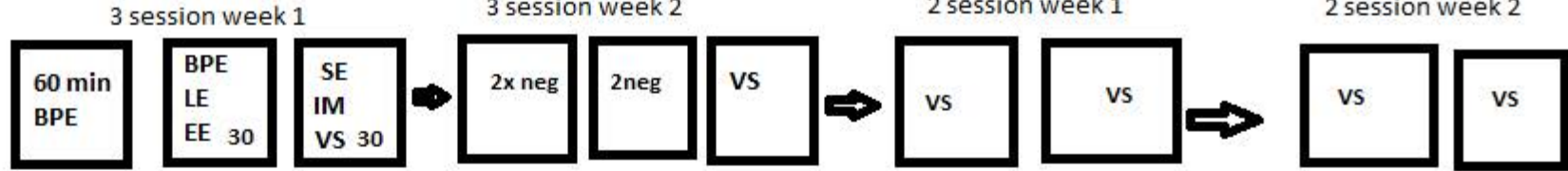
IMPLEMENTATION GRAND TOTAL _____/280

The **symptoms, questions** and **concerns** that are of highest priority to me today are:

8 WEEK PROGRAM - REMOTE

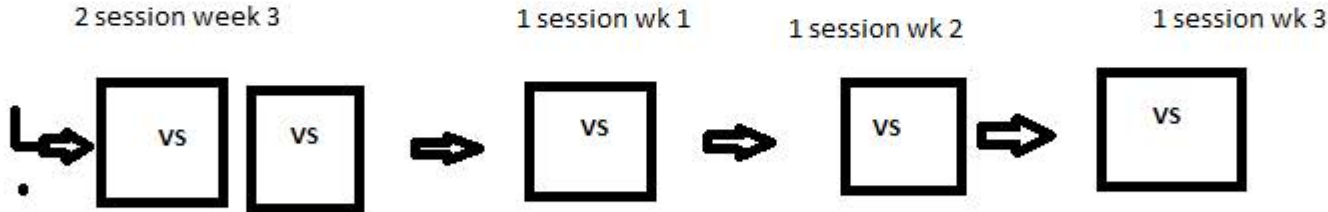
Deep Blue Sea
Live via Zoom
Attend sched
consult free otherwise
\$90 to book

60 free consult
Read, willing,
able & eager.



BPE Minimum 7 days from
consult.

- Free consult:
ARP DVD
Expectations
Signed forms:
consent, cancellation,
ROF: Medical history
Current Symptoms
Refrigerator list
CEP
Start of 7 days of
water
Schedule out appts
Deposit for care
Payment plan



VS - Vital Scan
Menuing symptoms,
introducing foods ARP
Terminating use of
medications
Work to symptom free.

PRN appointments once
client is 2x neg on vital
scans/ symptom free.

Supplements: 1 order to client - iodine \$18, Calmg \$49, Magnet \$21, Bands 2p \$10, Loalson \$19, floranorm
Client order - Vitamin C, B6 (pyridoxine), B12 cyanocobalamin, D3,
10 \$, \$10 \$12 \$6

Total fee: \$720.
Supplement Fee \$117
10% if pay in full to use
toward supplements %
\$72.00

client supplements \$40

Expectations to include: EMF/ELF support, bands, CEP, ofgal, liver, sleep hygiene