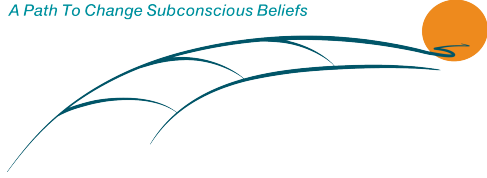


SUPPOSE

A Path To Change Subconscious Beliefs



Name: _____.

Gender: _____ Age: _____ Date: _____.

Phone/Cell: _____.

Email: _____.

Address: _____.

This is a journey together to investigate your perception of the life you are currently living and how to change beliefs that are influencing the balance in your life. Thank you for being curious!!

List any areas of your life you would like to change or balance Today (about 7-10):

Rate each item on your list from 0-10 (10 = the one I most want to change & Zero is no longer a problem)

Rate from 0-10	Things I would like to balance or change:
	1.
	2.
	3.
	4.
	5.
	6.
	7.
	8.
	9.
	10.
	Others:

Notes:

Please read over the form below prior to our meeting and feel free to complete any or all sections. You may bring the electronic copy, print it out or email your insights. This is for you to be able to identify areas in your life to begin the subconscious balance and this will guide our work together. *The intention for our work is to focus on the areas of your life that support you and then identify anything you feel is out of balance. **Then . . . You can simply Balance IT!***

Partner interview:

What is working for you in your life today?

What would you like to change that will improve your life?

What other Integrative Therapies or “Alternative” modalities have you experienced?

Do you feel supported in your Life? If so, by whom? [List most significant being, self or person(s)]

- Do you believe in one source (i.e. GOD), that is outside of you rendering Good and Evil?

OR

- Do you believe you are in control of your life and part of (or one with) the Universe?

Share *briefly* the strengths and support of the systems below that are related to your mind/body/spirit. Identify events in your life that **support** you related to the energy/body systems below.

Example: “My head- I think clearly and have a good sense of humor” or “My heart is strong and I feel love for people”

- 1). Limbs (Arms/Legs)

- 2). Head (All Parts)

- 3). Chest (Heart/Lungs)

- 4). Upper GI Tract (Swallowing, Stomach, Digestion)

- 5). Lower GI Tract (Excretion or Waste, weight)

- 6). Reproductive System

- 7). Activity

Other Strengths in your life?

Daily Spiritual Practices:

Please Check (X) any of the following “Labels”, diagnoses, or behaviors that you feel currently impact your life. Rate the conditions below using a scale of 1 to 10 (1= Little or No effect to 10= Completely effects my life). Note the age you remember the condition was brought to your attention.

X	Condition from Life Experience	Rate 1-10	Age (approximate)
	Exercise Motivation		
	Memory Improvement		
	Positive Parenting		
	Procrastination		
	Sales Success		
	Self-Confidence		
	Self-Discipline		
	Self-Esteem		
	Self Worth		
	Sports Enhancement		
	Study Habit Improvement		
	Test Taking Anxiety		
X	Conditions/Labels from Medical Profession	Rate 1-10	Age (approximate)
	Accident Trauma		
	Addictions		
	Allergies		
	Anxiety		
	Asthma		
	Cancer Support (Pain, Anxiety, Pre-Surgical, Post-Surgical)		
	Chronic Pain		
	FMS (Fibromyalgia)		
	Headaches		
	Hypertension		
	IBS (Irritable Bowel Syndrome)		
	Insomnia		
	Itching/psoriasis		
	Migraines		
	Post Traumatic Stress Disorder		
	TMJ/TMD (Temporal Mandibular Joint)		
	Weight Management		

X	Psychological Labels/Conditions	Rate 1-10	Age (approximate)
	Anger Management		
	Anxiety		
	Depression		
	Nail Biting		
	Panic		
	Phobias: Stage Fright, Fear of other Beings (Spiders, snakes, etc.)		
	Post Traumatic Stress Disorder		
	Psychological Diagnosis: Bipolar, Schizophrenia, etc.		
	Relaxation		
	Road Rage		
	Social Anxiety		
	Stress		
	Suicidal Ideations		
	Temper		
	Traumas		
	Others?		

Exclaimer: (Disclaimer:) We accept your 'assurance' that this is a partnership for your wellbeing. Healing is a complex part of our existence that may require one or more modalities working in concert and we are happy to suggest other healers or communities for you to partner with to continue your healing journey. While you visit with us, "feel the assurance" we impart for your healing and wholeness knowing we gratefully accept payment for joint successes.

Please use your powers of discernment and discrimination as you listen during our sessions; and accept only thoughts expressed that resonate with you. If you feel our services were ineffective, we are happy to refund your financial participation in our success. We would ask you share any concerns if you feel we might infringe upon your free will or disturb the rhythms of your seeking. We thank you for this consideration. Please continue to listen and receive the messages from your Body/Mind/Spirit as you journey.

Lyte,

Myra L. Lovvorn, RN, FNP-BC, AHN-BC
 PSYCH-K® Facilitator & Instructor
 Jin Shin Jyutsu Student & Practitioner
 804-814-9655
isupposellc@icloud.com
www.supposellc.com

“I am an extension of source energy, who has practiced my vibrational frequency to be in such alignment with my true nature that anything less than that feels off to me. And because I care about the way I feel, I guide myself easily now toward the things that feel good. And therefore I am ALWAYS on my path!” Abraham through Esther Hicks 2014

Use the space below to journal regarding any feelings you have to support your wellbeing!