Healing Touch Intake Form

Date: _____________ Client: _______________________________

Referred by: ___________________________________ Practitioner: ____________________________________

General Information

Address:

Phone: Email:

Emergency contact (name/phone): Legal guardian if under 18:

DOB: Age:

Education/Occupation:

Living Situation (Marital status/pets/alone; home as supportive or stressful? Social, family, personal support?):

Military Branch and years:

What change would you like to see in yourself as a result of this session?

Prior Energy Therapy/HT experienced?

Hobbies & interests:

Spiritual beliefs/practices/affiliations:

Is your belief a source of support to you? Word/Name(s) you use for Higher Power?

Your perceived strengths:

Self Care

Current self-care practices (exercise, meditation, relaxation, body care, journaling, etc):

Use scale 1-10, with 10 as an extreme issue, to rate **areas of concern.** Please describe any items rated 7 or above.

___Personal Relationships
___Physical Health
___Mental Health
___Emotional Health
___Spiritual
___Work
___Finances
___Eating/Nutrition
___Addiction

___Depression
___Mood swings
___Anger
___Anxiety
___Panic or anxiety attacks
___Trauma PTSD
___Memory problems
___Personal Direction

___Headaches
___Pain
___Fatigue/lethargy
___Hormonal issues
___Allergies
___Sleeping issues
___Safety
___Major Life Change
___Other

Relevant Health History

Current overall health condition: ___Excellent ___Very Good ___Good ___Fair ___Poor

To what do you attribute your current situation, symptom or health issue?

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Last physical exam:

Current health care professionals:

Health history (list medical conditions/diagnoses, with dates/years):

Hospitalizations/surgeries/accidents/injuries (date/year/complications?):

Mental health issues or diagnoses:

Mental/emotional traumas (condition/date/year):

Current prescription/over-the-counter medications/recreational drug use:

Supplements Used: ___Vitamins ___Minerals ___Herbs ___Homeopathy ___Flower Essences ___Other

Sleep quality/sleep aid usage/average hours of sleep per night:

Nutrition/Diet:

Elimination:

Daily water amount:

Caffeine/Alcohol/Tobacco/amount:

Is there **anything else** you want me to know? Any questions about me or Healing Touch?