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	___Depression	___Headaches
___Physical Health	___Mood swings	___Pain
___Mental Health	___Anger	___Fatigue/lethargy
___Emotional Health	___Anxiety	___Hormonal issues
___Spiritual	___Panic or anxiety attacks	___Allergies
___Work	___Trauma PTSD	___Sleeping issues
___Finances	___Memory problems	___Safety
___Eating/Nutrition	___Personal Direction	___Major Life Change
___Addiction		___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?

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?

