

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?