

Healing Touch Intake Form



Date: _____ Client: _____

Referred by: _____

Address:

Phone:

Email:

Emergency contact:

Legal guardian if under 18:

DOB:

Age:

Education / Occupation:

Living Situation (marital status, pets, alone; home as respite or stressful):

Military Branch and years:

What do you hope to experience from this session?

Prior Energy Therapy / HT experienced?

Current overall health condition: Excellent Very Good Good Fair Poor

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

Your primary reasons for seeking Healing Touch are:

- | | | |
|---|--|---|
| <input type="checkbox"/> Increase relaxation | <input type="checkbox"/> Chronic Illness / Disease | <input type="checkbox"/> Emotional Support |
| <input type="checkbox"/> Stress Management | <input type="checkbox"/> Surgery Support | <input type="checkbox"/> Spiritual Support |
| <input type="checkbox"/> Anxiety / Depression | <input type="checkbox"/> Cancer Treatment Support | <input type="checkbox"/> Major Life Change / Loss |
| <input type="checkbox"/> Pain Management | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Other _____ |

With the following scale, rate the areas of concern at this time:

Blank = None 1 = Minimal 5 = Moderate 10 = Extreme

- | | | |
|--|---|---|
| <input type="checkbox"/> Personal Relationships | <input type="checkbox"/> Depression | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Physical Health | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Mental/Emotional Health | <input type="checkbox"/> Anger issues | <input type="checkbox"/> Fatigue / lethargy |
| <input type="checkbox"/> Work | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hormonal issues |
| <input type="checkbox"/> Finances | <input type="checkbox"/> Panic or anxiety attacks | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Eating issues | <input type="checkbox"/> Emotional trauma / PTSD | <input type="checkbox"/> Sleeping issues |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Other (list) |

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

Hobbies & interests:

Spiritual beliefs / practices / affiliations:

Is your belief a source of support to you?

Word(s) you use for Higher Power?

Relevant Health History

Primary physician or health care professional:

Last physical exam:

Other types of health care professionals you see:

Current or chronic medical conditions, diagnosis, or treatments with dates:

Mental health issues or diagnoses:

Hospitalizations / surgeries (condition/date/year):

Significant physical or emotional traumas (condition/date/year):

Current prescription or over-the-counter medications:

Supplements Used:

Vitamins Minerals Herbs Homeopathics Flower Essences Other

Sleep quality & sleep aid usage:

Nutrition

Daily water amount:

Caffeine / Alcohol / Tobacco / Drug Usage / amount:

Is there anything else you want me to know?

Any questions about me or HT?