Healing Touch Intake Interview

Date ____/____/____

Practitioner: ________________________________ Referred By: ________________________________

Client: ________________________________ Phone: ____________________ Date of Birth: ____/____/____

Address: ____

E-mail: ________________________________ Occupation/Education: ____________________

Reason for Seeking HT Treatment(s):

Experience with Energy Medicine, Healing Touch or related Modality:

Social Support / Living Situation (family, alone, pets, etc.):

Health Professionals Seen and When (circle what applies):

Physician Nurse Practitioner Physical Therapist Nutritionist Chiropractor

Counselor/Therapist other: ____

Have you had any surgeries? Yes / No What kind? When?

Medical Problems/Health History (circle what applies)

Heart Lung Digestive Thyroid/hormonal Bronchitis Liver Asthma Heart Attack Circulation

Stomach Gall Blader Stroke Reproductive Organs Urinary Tract High Blood Pressure Clot Colon

Sexual Assault/Abuse Eating Disorder Seizures Cancer Diabetes Vision Kidneys Hearing

Depression Weight Problems Headaches Serious Accident/Trauma Alcohol/Drug Problems Allergies

Medications / Supplements (circle what applies):

Over the Counter Medicine Perscription Medication Homeopathics Vitamins/Supplements/Herbs/Remedies

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Do You Use? Type/Frequency? Alcohol Recreational Drugs Tobacco Caffeine

Nutrition:

Water Intake: Glasses per day ________________

Elimination: Regular Constipation

Sleep Patterns: Insomonia? Aides?

Personal Stresses : Use scale from 0 (no stress) to 10 (extreme)

From: Illness ____ Work ____ Relationships ____ Finances ____ Loss _____

Relaxation / Self Care: (circle what applies) Exercise/sports Hobbies Friends Support Groups

Describe: ____

Religious / Spiritual Practice and/or Belief:

What do you believe is the reason for your current health issues?

Is there anything else you want to tell me? Questions about me / Healing Touch?

Additional Information:

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