Healing Touch Intake Form

Date:_____________ Client: ________________________________

Referred by:____________________________________ Practitioner: _____________________________________

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:

___Increase relaxation
___Stress Management
___Anxiety / Depression
___Pain Management
___Headaches
___Back Pain
___Chronic Illness / Disease
___Surgery Support
___Cancer Treatment Support
___Emotional Support
___Spiritual Support
___Major Life Change / Loss
___Trauma
___Other _______________

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

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

___Personal Relationships
___Physical Health
___Mental/Emotional Health
___Work
___Finances
___Eating issues
___Addiction
___Depression
___Mood swings
___Anger issues
___Anxiety
___Panic or anxiety attacks
___Emotional trauma / PTSD
___Memory problems
___Headaches
___Pain
___Fatigue / lethargy
___Hormonal issues
___Allergies
___Sleeping issues
___Other (list)

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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 Healing Touch?

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