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:

Briefly describe what you wish to focus on during your session. We will have an opportunity to discuss this during your session as well.

What change would you like to see in yourself as a result of this session?

Prior Energy Therapy, Healing Touch or Flower Essence experienced?

Hobbies & interests:

Spiritual beliefs/practices/affiliations:

Is your belief a source of support to you? Do you have a 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?

