

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.

- | | | |
|---|---|--|
| <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 Health | <input type="checkbox"/> Anger | <input type="checkbox"/> Fatigue/lethargy |
| <input type="checkbox"/> Emotional Health | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hormonal issues |
| <input type="checkbox"/> Spiritual | <input type="checkbox"/> Panic or anxiety attacks | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Work | <input type="checkbox"/> Trauma PTSD | <input type="checkbox"/> Sleeping issues |
| <input type="checkbox"/> Finances | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Safety |
| <input type="checkbox"/> Eating/Nutrition | <input type="checkbox"/> Personal Direction | <input type="checkbox"/> Major Life Change |
| <input type="checkbox"/> Addiction | | <input type="checkbox"/> 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?