**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.

|  |  |  |
| --- | --- | --- |
| Personal Relationships  Physical Health  Mental Health  Emotional Health  Spiritual  Work  Finances  Eating/Nutrition  Addiction | Depression  Mood swings  Anger  Anxiety  Panic or anxiety attacks  Trauma PTSD  Memory problems  Personal Direction | Headaches  Pain  Fatigue/lethargy  Hormonal issues  Allergies  Sleeping issues  Safety  Major Life Change  \_\_\_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?