**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 supportive/stressful; social/family/personal support):

Military Service with Dates:

**HEALTH INFORMATION**

Current overall health condition: Excellent Very Good Good Fair Poor

Health concerns:

Current nutritional status: Excellent Very Good Good Fair Poor

Last physical exam date:

Current active healthcare professionals (physicians/D.O./chiropractor/nutritionist/bodyworkers/etc.)

Medical conditions with diagnoses dates/years:

Hospitalizations/surgeries (date/year/complications):

Accidents/physical injuries (date/year/complications):

Mental health conditions/disorders with diagnoses dates/years:

Sleep quality/sleep aid usage/average hours of sleep per night:

Current prescription/over-the-counter medications:

Supplements Used: Vitamins Minerals Herbs Homeopathic Flower Essences Other

Daily Water Amount:

Recreational drug/alcohol/tobacco use and frequency:

Current **Self-Care** practices (exercise, meditation, relaxation, body care, journaling, hobbies, interests):

Your perceived strengths:

**Spiritual** beliefs/practices/affiliations:

Is your belief a source of support to you? Word/Name(s) you use for Higher Power?

**AREAS OF CONCERN**

|  |  |  |
| --- | --- | --- |
| **Use scale 1-10, with 10 as an extreme issue, to rate the following.** | | |
| Personal Relationships  Physical Health  Mental Health  Emotional Health  Spiritual Concerns  Work  Finances  Eating/Nutrition  Addiction | Depression  Mood Swings  Anger  Anxiety  Panic/Anxiety Attacks  Memory Problems  Personal Direction  Emotional Trauma/PTSD  (Self or Family) | Headaches  Pain  Fatigue/Lethargy  Hormonal Issues  Allergies  Sleep Quality  Personal Safety  Major Life Change(s)  \_\_\_Other |
| **Brief description of items rates 7 or higher:** | | |

Prior Energy Healing/Healing Touch experience?

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

Is there anything else you wish to share or any question you have?