

# Healing Touch Intake Form



Date \_\_\_\_\_ Client \_\_\_\_\_

Referred by \_\_\_\_\_ Practitioner \_\_\_\_\_

## GENERAL INFORMATION

Address \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

Legal guardian if under 18 \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_

Education/Occupation \_\_\_\_\_

### Living Situation

Marital status \_\_\_\_\_  Pets  Live alone Home is  Supportive  Stressful

Social support:  Yes  No Family support:  Yes  No Personal support:  Yes  No

**Military Service**  Yes  No  N/A Dates: \_\_\_\_\_

## HEALTH INFORMATION

**Current overall health condition** \_\_\_\_\_ **Health concerns** *(describe below)*

**Current nutritional status** \_\_\_\_\_ **Nutritional concerns** *(describe below)*

**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 Essence  
 Other

**Daily Water Amount**     1-3 glasses/day     4-6 glasses/day     7-9 glasses/day     More than 9

**Recreational Drug Use**                      **Alcohol Use**                      **Tobacco Use**  
 Yes    Frequency: \_\_\_\_\_     Yes    Frequency: \_\_\_\_\_     Yes    Frequency: \_\_\_\_\_  
 No     No     No

**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?**     Yes     No

**Word/Name(s) you use for Higher Power?**

**AREAS OF CONCERN**

Use scale 1-10 by selecting number from drop-down list, with 10 as an extreme issue, to rate the following:

Personal Relationships	Depression	Headaches
Physical Health	Mood Swings	Pain
Mental Health	Anger	Fatigue/Lethargy
Emotional Health	Anxiety	Hormonal Issues
Spiritual Concerns	Panic/Anxiety Attacks	Allergies
Work	Memory Problems	Sleep Quality
Finances	Personal Direction	Personal Safety
Eating/Nutrition	Emotional Trauma/PTSD (Self or Family)	Major Life Change(s)
Addiction		Other

**Brief description of items rated 7 or higher** *(areas of concerns from previous page)*

**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?**