Healing Touch Intake Form

Healing Touch Program
ENLIGHTEN EMPOWER PRACTICE

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 -select- **Health concerns** *(describe below)*

Current nutritional status -select- **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
☐ Yes Frequency: _____
☐ No

Alcohol Use
☐ Yes Frequency: _____
☐ No

Tobacco Use
☐ Yes Frequency: _____
☐ 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?