

Healing Touch Intake Interview

Date ____/____/____

Practitioner: _____ Referred By: _____

Client: _____ Phone: _____ Date of Birth: ____/____/____

Address: _____

E-mail: _____ Occupation/Education: _____

Reason for Seeking HT Treatment(s):

Experience with Energy Medicine, Healing Touch or related Modality:

Social Support / Living Situation (family, alone, pets, etc.):

Health Professionals Seen and When (circle what applies):

Physician Nurse Practitioner Physical Therapist Nutritionist Chiropractor
Counselor/Therapist other: _____

Have you had any surgeries? Yes / No What kind? When?

Medical Problems/Health History (circle what applies):

Heart Lung Digestive Thyroid/hormonal Bronchitis Liver Asthma Heart Attack Circulation
Stomach Gall Bladder Stroke Reproductive Organs Urinary Tract High Blood Pressure Clot Colon
Sexual Assault/Abuse Eating Disorder Seizures Cancer Diabetes Vision Kidneys Hearing
Depression Weight Problems Headaches Serious Accident/Trauma Alcohol/Drug Problems Allergies

Medications / Supplements (circle what applies):

Over the Counter Medicine Perscription Medication Homeopathics Vitamins/Supplements/Herbs/Remedies

Do You Use? Type/Frequency? Alcohol Recreational Drugs Tobacco Caffeine

Nutrition:

Work patterns: Regular Irregular

Eating patterns: Regular Irregular

Elimination patterns: Regular Irregular

Sleep patterns: Regular Irregular

Personal Stresses: Use scale from 0 (no stress) to 10 (extreme)

From: Illness ____ Work ____ Relationships ____ Finances ____ Loss ____

Relaxation / Self Care: (circle what applies) Exercise/sports Hobbies Friends Support Groups

Describe:

Religious / Spiritual Practice and/or Belief:

What message do you think your body is sending you with your current health concerns?

Is there anything else you want to tell me? Questions about me / Healing Touch?

Additional Information: