

Healing Touch Intake Interview

Date ____/____/____

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:

Living Situation (partner, alone, social supports, pets):

Health Professionals Seen and When (circle what applies):

Physician Nurse Practitioner Physical Therapist Nutritionist Chiropractor
Counselor/Therapist _____

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 Blader 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

Notes: _____

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:

Elimination: Regular Constipation

Water Intake: Glasses per day _____

Sleep Patterns: Insomnia? Aides?

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 do you believe is the reason for your current health issues?

Is there anything else you want to tell me?

Additional Information: