Healing Touch Intake

Name: Date:
Address:
Phone: Email:
Date of Birth: Referred By:
Emergency Contact Person: EC Number:

Experience with Energy Medicine or other related modalities:

Religious Affiliations:

Occupation/ Daily Activity:

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

Healing care professional you see:

Health/Medical History:

Surgeries? When?

Accidents?

Medications:

Supplements, herbs, homeopathic:

Allergies:

History of addictions:

Diet/ Nutrition:

Sleep – hours/night:

Sleep – adequate/restless

Exercise – type:

Exercise – frequency:

Stress [0 (low) – 10 (high)]

Professional life:____ Personal life:_____ Other:____

Stress Reduction/ Relaxation Techniques:

Meditation/Spiritual Practices: