Healing Touch Intake Form

Healing Touch Program
ENLIGHTEN EMPOWER PRACTICE

Date: **Client:**

Referred by:

GENERAL INFORMATION

Address:

Phone: Email:

Emergency contact (name/phone): Legal guardian if under 18:

DOB: Age:

Education/Occupation:

Living Situation (Marital status/pets/alone; home supportive/stressful; social/family/personal support):

Military Service with Dates:

HEALTH INFORMATION

Current overall health condition: ___Excellent ___Very Good ___Good ___Fair ___Poor

Health concerns:

Current nutritional status: ___Excellent ___Very Good ___Good ___Fair ___Poor

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 Essences __Other

Recreational drug/alcohol/tobacco use and frequency:

Current **Self-Care** practices (exercise, meditation, relaxation, body care, journaling, hobbies, interests):

Spiritual beliefs/practices/affiliations:

Is your belief a source of support to you? Word/Name(s) you use for Higher Power?

AREAS OF CONCERN

Prior Energy Healing/Healing Touch experience?

What change would you like to see in yourself as a result of this session?

Use scale 1-10, 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	__ Sleep
__ Work	__ Personal Direction	__ Major life changes
__ Finances	__ Emotional Trauma	__ Other:
__ Eating/Nutrition	__ PTSD	__ Other:
__ Addiction	__ Relationships Family/Spouse	

Brief description of items rates 7 or higher:

During the session gentle/light touching may occur; do I have permission to touch? If touch makes you uncomfortable, I do not need to, and the session/results will be the same. **Y / N**
Essential Oils may be used during the session. Are you ok with the use of Essential Oils? **Y / N**
Plant brushing is another modality that I may implement if I am called to use. Are you ok with herbs/flowers/plants to be brushed gently on your body? **Y / N**

Do I have permission to take a picture of our session at the end for my social media / website/ portfolio? Your information will not be release and your face can be blur out.

- ☐ Yes: I give permission for my session to be posted and do not need my face to be blurred
- ☐ No: I do not want my picture to be taken
- ☐ Yes: I give permission for my picture to be taken but I do want my face blurred.

Signature: _____ Date: _____
Parent Signature (Minor): _____ Date: _____