Energy Healing Client Intake Form

(Initial Meeting Assessment)

Name_____**Date**_____

Address_____

Phone_____**Birthday/age**_____

Email_____**Occupation**_____

Married_____**Single**_____**Divorced**_____**Children**_____**Ages**_____

Spiritual Practice_____

Primary Health Care Provider (Physician)_____

Other Health Providers_____

Presenting Concern_____

_____

Allergies or Sensitivities_____

Surgeries: What procedures? _____

Serious illnesses_____

Motor vehicle accidents_____

Falls/injuries_____

Sleep Quality: How much _____Do you wake at night, use a sleep aid and/or have Insomnia?

_____

Exercise: Regularly ___Yes ___No Frequency_____ What kind? _____

_____

Daily water consumption_____ Caffeine consumption ___Yes ___No ___
Frequency_____

Do you Smoke? ___Yes ___No ___

Food Allergies? ___Yes ___No What Kinds? _____

Medications? ___Yes ___No
List:_____

Supplements or other forms of alternative medicines? ___Yes ___No ___ List:_____

Skin Type: Face: ___Normal___Dry___Oily___Combination

Body: ___Normal___Dry___Oily___Combination

Check All That Apply Past and Present:

Heart Disease ___Gall Bladder ___ Hepatitis ___ Kidney ___Thyroid ___Nerves ___Stomach ___ Pancreas___ Colon ___Lungs___ Back and Joints ___Reproductive system ___Hormone system ___ Bones___ Muscles___

Have you ever had Cancer? Where?_____

Do You Presently Have:

Skin Issues: Eczema/Dermatitis ___Acne ___Scars ___Dandruff ___Psoriasis ___Hair loss ___Herpes Simplex___ Athlete's Foot___Warts___Other_____

Digestive Issues: Heartburn ___Indigestion ___Bloating___ Gas ___Diarrhea ___Constipation ___ Nausea ___Vomiting ___Mouth Sores ___Colitis ___Irritable Bowel___

Circulation Issues: Heart Palpitations ___Tightness in Chest ___Low Blood Pressure ___High Blood Pressure ___Fluid Retention ___Varicose Veins ___Shortness of Breath ___Blood Clots ___Lymph ___ Edema ___Poor Circulation___

Nervous System Issues: Depression ___**Headaches:** Sinus ___Tension ___Migraine___ Neuralgia___Shingles___Neuropathy___Stroke___Parkinson's___Multiple Sclerosis ___Seizure Disorder ___Dementia or impaired memory___

Respiratory Issues: Sore Throat ___Cold ___Flu ___Sinus Issues ___Bronchitis ___Pneumonia ___ Shortness of Breath ___Asthma ___Swollen Glands___

Muscle Issues: Cramps ___Sprains ___Arthritis ___Rheumatism ___Back or Joint Issues ___ Jaw Pain ___Inflammation ___Spasms___

Urinary Issues: Frequency ___Bladder Infections ___Stones ___Kidney Infection___

Endocrine Issues: Thyroid Dysfunction ___Adrenal Dysfunctional ___Diabetes___

For Women:

Menstrual Cycles Regular ___Irregular Periods ___Menstrual Pain ___PMS ___Vaginal Thrush___Infertility___Herpes___Edometriosis___Pregnant___Trimester___First___Second___ Third___Menopausal___Hot flashes ___ Bloating ___Night Sweats___ Irritability ___ Other _____

For Men:

Infertility ___Prostate Issues _____Other Complaints _____

Pain Scale 0-10 (0 being none and 10 being worst) ___ Stiffness ___Inflammation ___

Have You Been Diagnosed With: Bacteria Infection ___Viral Infection ___Fungal Infection___

Any Other Long-Term Health Issues?

_____

Emotional Issues:

Anxiety___Depression___Worry___Fear___Anger___Apathy___Empty___Grieving a Loss___Who?_____Despair___Disappointment___Sorrow___Frustration___Impatience___ Apprehension ___Powerlessness ___Terror ___Panic Attacks ___Resentment ___Remorse ___Regret___ Lethargy ___Listlessness ___Boredom ___Moodiness ___Mood Swings ___ Inadequacy ___ Mental Fatigue ___ Irritable ___Unworthiness ___Lacking Confidence ___Suicidal ___

Do You Have a Plan? Yes ___ No ___ If yes, what is your plan? _____

_____

Mental Issues:

Difficulty in Concentrating ___Constant Irritability ___Lack of Interest in Life ___Feeling Unable to Cope ___Dreading the Future ___Fear of Being Alone___ Mental Fatigue___ Irritable___

Stress:

How would you rate you stress level? Low ___Medium ___High___

Lack of Appetite ___Unnatural Craving ___Constant Tiredness ___Frequent Crying or Wish to Cry ___Nail Biting ___Nervous Twitches ___Inability to Sit Still___

Work Stress:_____

Home Stress:_____

Self-Care Activities:_____

Short Term Goal: (presenting physical, emotional, mental, or spiritual issues that you would like to address in the 1st session)

_____

_____

_____

Long Term Goal:

_____

_____

_____

Client's Signature_____Date_____