CLIENT INTAKE FORM*

ENERGETICS BOUTIQUE - INTEGRATED ENERGY MEDICINE HEALING TOUCH

Date	Practitioner	
Client Name	Referred By	Church Home, if any
Age/DOB	Living Situation (marital status/pets/alone; home supportive/stressful; social/family/personal support/birth order)	
Phone		
Emergency Contact		
Address		
E-mail		
Education		
Occupation	Birth/adoption into family whose ancestors were slaves?	
Military Service (with dates)		
Spiritual (beliefs/practice/affiliations)	In what way is your belief a source of support to you? What words or names do you use for Higher Power?	
Current Stress Level (Encircle) Low 1 2 3 4 5 6 7 8 9 10 High		
Identify primary source of stress		

AREAS OF CONCERN

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	____Allergies
____Work	____Memory Problems	____Sleep Quality
____Finances	____Personal Direction	____Personal Safety
____Eating/Nutrition	____Emotional Trauma/PTSD	____Major Life Change(s)
____Addiction	(Self or Family)	____Other

Brief description of items rates 6 or higher:

*Informed by client session documentation forms of Healing Touch Program and Energy Medicine Specialist Program; and the Field of Energy Psychology.

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CURRENT SELF CARE PRACTICES

Such as exercise, hobbies, any medication or rituals helpful to you and how often you practice them.	(daily, x per week, occasionally or none) What gets in the way of your meeting your physical, mental, emotional, spiritual needs?

Current overall health condition:

____Excellent ____Very Good ____Good ____Fair ____Poor

Current nutritional/addictions status (yours or in family growing up):

____Excellent ____Very Good ____Good ____Fair ____Poor

Water/Sleep per day? How many hours per day?

What is considered your strengths?

What do you believe is the cause of your current health issues?

TRADITIONAL HEALTHCARE INFORMATION

Last physical exam date: Referral from:

Current Medications/Supplements (include dosages and "what for", (may attach list)

Current Health Care Providers (may attach list)

Significant Past Medical History: (include surgeries, falls/blows to the body w/sprains, breaks, concussions, traumas, diagnoses - Give dates/years) (may attach list)

ADDITIONAL NOTES

For Client: As you journey in life, what would you say "it is that you intend to be?"

For Practitioner: Any intuitive messages?

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