KATIE TANDON, LMT

HEALING TOUCH INTAKE FORM

Today's Date: _____

Patient Name: Last _____ First _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: (_____) _____ -_____ Cell phone: (_____) _____-_____

Date of Birth: ____/____/____ Age: _____ Sex: (M or F)

E-mail address: _____

Who may we thank for referring you? _____

In case of emergency, contact:

Name: _____ Relationship: _____

Home phone: (_____) _____ - _____ Work phone: (_____) _____ -_____

Practitioner: _____ Phone_____

GENERAL

Education / Occupation: _____

Living Situation (marital status / pets / alone; home as supportive or stressful): _____

_____

Personal Supports: _____

Military: Y / N (branch and years): _____

Prior Energy Therapy / Healing Touch experience: _____

Hobbies / Interests: _____

Spiritual Beliefs, Practices and/or Affiliations: _____

Is your belief a source of support for you? Y / N
Word / Name you use for a higher power: _____

What are your perceived strengths? _____

_____

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SELF CARE

Current self-care practices (exercise, meditation, relaxation, body care, journaling, etc.): _____

_____

Use a scale of 1 – 10, with 10 as an extreme issue, to rate areas of concern. Describe any items rated 7 or above:

___ Personal Relationships	___ Depression	___ Headaches	___ Eating/Nutrition
___ Physical Health	___ Mood Swings	___ Pain	___ Personal Direction
___ Mental Health	___ Anger	___ Fatigue/Lethargy	___ Major Life Change
___ Emotional Health	___ Anxiety	___ Hormonal	___ Addiction
___ Spiritual	___ Panic Attacks	___ Allergies	___ Finances
___ Work	___ Trauma/PTSD	___ Sleep	___ Memory
___ Safety	___ Other		

RELEVANT HEALTH HISTORY

Current overall health condition: ___ Excellent ___ Very Good ___ Good ___ Fair

To what do you attribute your current situation, symptoms or health issue? _____

_____

Last Physical Exam: _____

Hospitalizations / Surgeries / Injuries (date / complications, if any): _____

_____

Current Health Care Professionals: _____

Mental Health Issues / Diagnoses: _____

Mental / Emotional Trauma (date / condition): _____

_____

Current prescription drug / over-the-counter medications / recreational drug use: _____

_____

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Supplements Used: ___ Vitamins ___ Minerals ___ Herbs ___ Homeopathy ___ Flower Essences

___ Other: _____

Sleep Quality / Sleep Aid Usage / Average Hours of Sleep per night: _____

_____

Nutrition / Diet

Elimination: _____

Daily Water Amount: _____

Caffeine / Alcohol / Tobacco Amount: _____

_____

Reason for seeking healing touch therapy_____

_____

Is there anything else you want me to know? Any questions about me or Healing Touch?

_____

_____

I certify that all information stated on this form is correct to the best of my knowledge.

_____ _____

Patient Signature Date

OFFICE USE ONLY _____

DX:

Notes: