Health History Intake

Date: _____

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip:_____

Home Phone/Cell: _____ Email: _____

Referred by? _____

Have you had experience with Healing Touch or other energy modalities: Yes No

Are you under the care of a doctor, counselor or other health care practitioners at this time? Yes No

___ Primary Care Physician ___ Other

Do you have any illnesses, injuries, trauma, or surgeries that may be affecting your health now? Yes No

If yes, please explain:

_____

_____

Are you experiencing any symptoms (pain, tension, anxiety, etc)? Yes No

If yes, please explain:

_____

_____

Does this affect your daily activities (sleep, exercise, decision-making, relationships)? Yes No

If yes, please explain:

_____

_____

For symptoms/concerns that apply to you, please rate your distress level using a 0-10 scale,
10 being most intense/severe/challenging. Enter the number/rating in the box left of symptom/concern.

	Accident/Trauma		Depression		Mental Health
	Alcohol/drug use		Digestive Issues		Physical Health
	Allergies		Emotional Health		Post Operative Pain
	Anger		Grief/Loss/End of Life		Sexual Assault/Abuse
	Anxiety		Headaches		Stress (Home)
	Cancer Treatment Side Effects		Hormonal imbalances		Stress (Work)
	Chronic Pain		Memory Concerns		Other _____

How do you rate your quality of sleep? ___Poor ___Good ___Very Good

Daily Balanced Nutritional Intake ___Yes ___No
Daily Hydration ___Yes ___No
Daily Elimination ___Yes ___No

Current self-care practices (i.e. physical activities, hobbies, meditation, guided imagery, journaling, supportive connections, acupuncture, qigong, massage, etc):

Spiritual or religious belief/practice/higher source:

What is your desired outcome for today's session?

Anything else I should know? Questions?

In case of emergency, I authorize Lori Volding to contact the following person/s:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____