HEALING TOUCH INTAKE

Peaceful Transitions: Healing Touch for Grief, Loss and End of Life

Judy Tills CHTP
612-810-1576

Date: ______________________ Name: ____

Address ____

Phone: Home: ____________________ Cell: ____

Preferred Phone: ________________________

Email: ____

Date of Birth: ____________________ Age: ________________ Referred by: __________

Emergency Contact: (name, relationship, phone) ______________________________________

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Reason for Coming:

Occupation/Daily Activity:

Living Situation/Social Support (family, pets, friends, etc.)

Experience with Energy Medicine or Other Related Modality (massage, acupuncture):

Health Care Professionals You See (Physician, Nurse, PT, Counselor, etc.):

Health/Medical History: Please list any illnesses/health issues/surgeries (include date of surgeries):

Accidents:

Medications:

Supplements, Herbs, Homeopathics:

Allergies:

History of Addictions:

Diet/Nutrition:

Sleep/Hours per night/any challenges?

Exercise (What kind? Frequency?):

Stress Reduction/Relaxation Techniques:

Spiritual Practices:

Any Difficulties Focusing or Concentrating?

Pain: (0 to 10) (0=no pain, 10=very painful. Where located? Describe type of pain; i.e., throbbing, aching, sharp, etc.):

Stresses: 0 to 10, (0=no stress, 10=high stress):

Personal:
Work:
Other:

Wellness Assessment/PEMS: 0=low, 10=high level of wellness

Physical: (Energy Level): ____________________
Emotional: ;(Happiness and Joy): ____________________
Mental: (Positive outlook and self-talk) ____________________
Spiritual (Connection to something greater than yourself): ____________

Goals for Healing:

Short Term:

Long Term:

Is there anything else you want me to know about you?