☐ Add to database

Referred by:_____

Healing Touch Transitions Client Intake

Name:	Age / DOB:	Today's Date:
Phone:	Occupation:	
Emergency Contact:		
Address:	E-mail Address:	
Living Situation (pets, alone, etc.):		
Personal/Work Stress:		
Stress Reduction / Relaxation: Meditation/Spiritual Practice: Daily x per week Occasionally None		
Exercise:	Hobbies:	
Nutrition/Addictions	Current Medications/Supplements	
Water/Sleep		
Current Health Care Providers:		
Significant Past Medical History: (Traumas, Accidents, Surgeries)		
What do you hope to get out of this session? What do you believe is the reason for your current health issue/s? Anything else you would like to tell or ask me?		