

### 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 for each 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 Elimination	___Yes	___No
Daily Hydration	___Yes	___No	Caffeine	___Yes	___No
Alcohol	___Yes	___No	Tobacco	___Yes	___No

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

Religious or Spiritual belief/practice/higher source:

What is your desired outcome for today's session?

What are your long term health goals?

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\_\_\_\_\_