

CLIENT INTAKE INFORMATION
HEALING TOUCH/ HERBAL/ MANUAL THERAPY

NAME:

DATE:

AGE/DOB

ADDRESS:

PHONE:

WORK STRESS:

PERSONAL STRESS:

REASON FOR APPT:

LIFESTYLE/ROUTINES (exercise, sleep pattern, diet, relaxation etc...)

SPIRITUAL PRACTICE /MEDITATION PRACTICE:

TYPICAL DAY OF MEALS: (how I usually eat, favorite foods, food sensitivities, etc...)

CURRENT MEDICATIONS OR VITAMINS/SUPPLIMENTS:

MEDICAL HISTORY/CURRENT HEALTH CARE SUPPORT: (please be specific, add childhood injuries/events, even small things you may not think matter now)

