Please take the time to fill this out with as much detail as you are comfortable with.

CLIENT INTAKE INFORMATION
HEALING TOUCH/ HERBAL/ MANUAL THERAPY

NAME: DATE:
AGE/DOB
ADDRESS:
PHONE:
EMAIL:

HEIGHT/ WEIGHT:

WHO REFERRED YOU?

REASON FOR APPT:

OTHER CURRENT KNOWN IMBALANCES:

What makes it improve?
What makes it worse?

CURRENT LIVING SITUATION:

CURRENT WORK SITUATION:

HEALTH CARE PROFESSIONALS YOU ARE WORKING WITH:

CURRENT MEDICATIONS, SUPPLIMENTS:

PAST SURGERIES:

PAST INJURIES OR SIGNIFICANT HEALTH PATTERNS
PERTINENT FAMILY MEDICAL HISTORY:

TYPICAL DAY OF MEALS/FLUIDS: (how you usually eat, favorite foods, food sensitivities, include drugs and alcohol use, etc…)

DESCRIBE YOUR DIGESTION- Include elimination patterns.

DO YOU SMOKE?
WHAT DO YOU DO FOR EXERCISE?

HOW DO YOU GENERALLY FEEL EMOTIONALLY?

ARE YOU BOTHERED BY WEATHER CHANGES?

DESCRIBE YOUR SLEEP PATTERN

DO YOU LIKE YOUR BODY?

WHAT DO YOU DO FOR HOBBIES/RECREATION?

WHAT GIVES YOU JOY?

IS THERE ANYTHING ELSE YOU THINK IT'S IMPORTANT FOR ME TO KNOW RIGHT NOW?