

Client Information for: _____

Date:

Address:

Home Phone:

Cell Phone:

Work Phone:

Email:

Emergency contact name & phone:

DOB:

Age:

Gender: M F

Legal guardian if under 18:

Referred by:

Client Informed Consent signed

Occupation:

Employer:

Relationship/Family status:

Military History - Branch of service and years:

Prior energy therapy/work experienced:

Current health condition: __Excellent __Very Good __Good __Fair __Poor

What is your primary reason(s) for seeking energy therapy?

__Relaxation

__Stress Management

__Pain Management

__Emotional Support

__Spiritual Support

__Major Life Change or Loss

__Surgical Support

__Medical Procedure Support

__Cancer Treatment Support

__Depression

__Chronic Illness/Disease

__Other (list):

Please use the following scale to rate any areas of concern at this time:

Blank = None 1 = Minimal 2 = Moderate 3 = High 4 = Very High 5 = Extreme

__ Personal Relationships

__ Depression

__ Headaches

__ Your Health

__ Mood swings

__ Pain

__ Work

__ Anger issues

__ Fatigue

__ Finances

__ Anxiety

__ Hormonal issues

__ Other (list)

__ Panic or anxiety attacks

__ Sleeping issues

__ Emotional trauma

__ Eating issues

__ Memory problems

__ Smoking

__ Substance use

Continued on back

Sue Walker ☯ **Wellness Within^{LLC}**

Healing Touch Certified Practitioner (HTCP) ☯ Certified Reiki Master (CRM)

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Current self care practices (exercise, meditation, relaxation, body care, journaling, etc):

Hobbies & interests:

Spiritual beliefs/affiliations:

Relevant health history

Primary physician or health care professional:

Last physical:

Other health care professionals you currently see:

Current or chronic medical conditions, diagnosis, or treatments:

Mental health issues or diagnoses:

Hospitalizations or surgeries (condition & date):

Significant traumas (physical or emotional):

Allergies:

Current prescription medications:

Current Supplements Used:

Vitamins Minerals Herbs Homeopathics Flower Essences Other

Sleep quality & sleep aid usage:

Other conditions/information:

Nutrition

Quality of diet:

Special dietary needs:

Daily water amount:

Daily caffeine amount:

Alcohol usage / amount:

Tobacco usage / amount:

Other information:

01.01.10

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