Healing Beyond Borders
Educating and Certifying the Healing Touch ®

Assessment for Healing Touch Session

Initials:_________________Gender Identity __________DOB ___/___/___Phone ________________

Address ___________________________________Email ___________________________________

Date ___/___/_____ Session # _____________

Physical Presentation

Mobility

Mood

Comfort

Reason for Session

Signs & Symptoms of Complaint

Aggravating Factors

Interventions used

Personal Information

Family Structure

Living arrangement

Employment

Social Life

Spiritual affiliation

Other important organizations

Major Stress factors

Self Care

Nutrition

Sleep pattern

Exercise

Spiritual Practices

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Medical History

Current problems & interventions used

Chronic problems & care providers

Surgeries

Injuries

Family illnesses history

Medication/ Supplements

Energetic Assessments

Chakras

Field Shape & Size

Areas of Congestion

Problems: (Priortize)

Mutual Goals –Short Term

Long Term

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