Healing Beyond Borders
Educating and Certifying the Healing Touch ®

Initial Intake/Assessment for Healing Touch

Initials/Name:_____ Gender Identity _____ DOB ___/___/___ Session #____

Address _____ Email _____

Date ___/___/____ Phone _____Health Care Provider(s): _____

Purpose of Visit *(History of issue/concern; Date of onset, duration, symptoms; Changes/Progression/Evolution; Intensity/Severity of symptoms; Aggravating factors; Interventions used; Impact on life)* _____

Overall Health Presentation *(History of previous health/wellness and and dates/onset of illness, injuries, traumas, surgeries)* _____

Medications, OTC Medications / Supplements / Recreational Drugs. (*List & describe reason for taking)*
History of any allergies _____

Exercise, Sleep Patterns and Nutritional Support _____

Social / Cultural
Family Structure / Living arrangement_____
Employment_____
Social Life_____
Spiritual Life_____

Pain: (Source / site / severity) 0 none - 10 worst

_____

Stress: (Personal and/or Professional/work) 0 none - 10 worst

Physical, Emotional, Mental, Spiritual, Social, Cultural (PEMSSoC) Wellness (0 - 10; 10 = high level wellness)
P_____ E_____ M_____ S_____ So_____ C_____

Subjective Data from patient: *(Summary of information shared by the patient during the intake):*

Objective Practitioner Observations *(Summary of the practitioner's observations and impressions during the intake; patient movement, expressions, mood, body language):*

Assessment *(Conclusions and problem statements based on data and observations) Continue with Healing Touch Session documentation.*