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 previously; 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 wellness (PEMSSoC) (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.*