# Health History

Date: ____/____/____

Name: _____ Phone: _____ Date of Birth: ____/____/____

Address:_____
street address city state zip

E-mail: _____ Occupation: _____

Would you like to receive my quarterly newsletter & occasional e-mails informing you of upcoming classes? Y N

Referred By: _____

**Reason for seeking energy healing treatment(s):**

**Experience with Healing Touch or other energy healing modality:**

**Social Support / Living Situation (family, alone, pets, etc.):**

**Health Care Professionals you currently see:**

**Have you had any surgeries? Yes / No What kind? When?**

**Medical Problems/Health History (circle what applies)**

| | | | |
|---|---|---|---|
| Allergies | Depression/Anxiety | Headaches | Serious Accident/Trauma |
| Arthritis | Diabetes | High/Low Blood Pressure | Sexual Assault/Abuse |
| Auto-immune | Digestive Issues | Injury | Skin Conditions/Sensitivities |
| Cancer | Epilepsy | Joint Pain | Stroke |
| Chronic pain | Fibromyalgia | Migraines | **Females:** PMS |
| Chronic Fatigue Syndrome | | Osteoporosis | Pregnant? Y N |

Other chronic conditions or health concerns?

**Medications / Supplements (circle what applies):**

Over the Counter Medicine  Prescription Medication  Vitamins/Herbs  Homeopathics

**Please Describe:**

**Nutrition:**
Quality of diet:

Daily water amount:

Daily caffeine amount:

Alcohol: usage/amount:

Tobacco: usage/amount:

Other information:

**Sleep Patterns:** Insomnia?  Sleep Aides?

Please Describe:

**Personal Stresses: Use scale from 0 (no stress) to 10 (extreme)**

From: Illness ____ Work ____ Relationships ____ Finances ____ Loss _____ Other_____
Comments:

**Relaxation / Self Care:** (circle what applies) Exercise/sports  Hobbies  Friends
Support Groups  Meditation  Journaling
Other:_____

**Spiritual beliefs and/or practices:**

**Do you feel a sense of spiritual fulfillment in your life? Y N**
**Comments:**

**What do you believe is the reason for your current health issues?**

**Additional Information:**