

# Healing Touch Intake Form



Date \_\_\_\_\_ Client \_\_\_\_\_

Referred by \_\_\_\_\_ Practitioner \_\_\_\_\_

## GENERAL INFORMATION

Address \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

Legal guardian if under 18 \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_

Education/Occupation \_\_\_\_\_

### Living Situation

Marital status \_\_\_\_\_  Pets  Live alone Home is  Supportive  Stressful

Social support:  Yes  No Family support:  Yes  No Personal support:  Yes  No

**Military Service**  Yes  No  N/A Dates: \_\_\_\_\_

## HEALTH INFORMATION

**Current overall health condition** \_\_\_\_\_ **Health concerns** *(describe below)*

**Current nutritional status** \_\_\_\_\_ **Nutritional concerns** *(describe below)*

**Last physical exam date** \_\_\_\_\_

**Current active healthcare professionals** *(physicians/D.O./chiropractor/nutritionist/bodyworkers/etc.)*

**Medical conditions with diagnoses dates/years**

**Hospitalizations/surgeries** *(date/year/complications)*

**Accidents/physical injuries** *(date/year/complications)*

**Mental health conditions/disorders with diagnoses dates/years**

**Sleep quality/sleep aid usage/average hours of sleep per night**

**Current prescription/over-the-counter medications**

**Supplements Used**     Vitamins     Minerals     Herbs     Homeopathic     Flower Essence  
 Other

**Daily Water Amount**     1-3 glasses/day     4-6 glasses/day     7-9 glasses/day     More than 9

**Recreational Drug Use**

Yes    Frequency: \_\_\_\_\_  
 No

**Alcohol Use**

Yes    Frequency: \_\_\_\_\_  
 No

**Tobacco Use**

Yes    Frequency: \_\_\_\_\_  
 No

**Current Self-Care practices**

Exercise     Meditation     Relaxation     Body Care     Journaling     Hobbies     Interests

**Your perceived strengths**

**Spiritual beliefs/practices/affiliations**

**Is your belief a source of support to you?**     Yes     No

**Word/Name(s) you use for Higher Power?**

**AREAS OF CONCERN**

Use scale 1-10 by selecting number from drop-down list, with 10 as an extreme issue, to rate the following:

Personal Relationships	Depression	Headaches
Physical Health	Mood Swings	Pain
Mental Health	Anger	Fatigue/Lethargy
Emotional Health	Anxiety	Hormonal Issues
Spiritual Concerns	Panic/Anxiety Attacks	Allergies
Work	Memory Problems	Sleep Quality
Finances	Personal Direction	Personal Safety
Eating/Nutrition	Emotional Trauma/PTSD (Self or Family)	Major Life Change(s)
Addiction		Other

**Brief description of items rated 7 or higher** *(areas of concerns from previous page)*

**Prior Energy Healing/Healing Touch experience?**

**What change would you like to see in yourself as a result of this session?**

**Is there anything else you wish to share or any question you have?**

# **Client Agreement for Services, Disclosures & Consent for Treatment for Healing Touch Sessions with**

**Janice Gagnon-Warr, RN, HN-BC, HTCP, CCAP  
227 Union St Suite 712  
New Bedford, MA  
508-308-4356**

## **Definition of Healing Touch**

Healing Touch is a holistic integrative therapy intended to clear, balance and energize the human energy system in order to facilitate physical, emotional, mental and spiritual self-healing.

The trained practitioner uses gentle light touch with heart centered intention. Healing Touch is intended to complement and not replace any prescribed medical care. Practitioners do not diagnose conditions or prescribe treatment.

## **Session Information**

Sessions are 60-90 minutes long.

The fee per session is 125.00.

Practitioner is not a provider for any insurance carrier and will provide an invoice for sessions upon request.

## **Appointment Cancellation Policy**

I agree to give a 24-hour notice if it is necessary for me to cancel an appointment. My practitioner reserves the right to charge me for the session if sufficient notice is not given.

## **Confidentiality**

All client information and records are treated in a confidential manner and no information will be given to anyone without my prior written consent, except in situations governed by law.

## **Disclosures**

I do not diagnose conditions or prescribe treatments.

No specific claims will be made by the practitioner regarding results from the Healing Touch session.

Treatment Goals will be mutually identified as part of the assessment and clients have input in the goal setting process.

## **Practitioner Liability Insurance :**

*The Energy Medicine Professional Association*

**Hold Harmless Clause**

Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless, Practitioner Name, from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).

**Client Consent for Treatment**

\_\_\_ (*initials*) I have read this document and been given the opportunity to ask questions regarding this document and Healing Touch sessions.

\_\_\_ (*initials*) I take responsibility to inform my practitioner of any changes in my health status.

\_\_\_ (*initials*) Yes, I give permission for light touch.

**Signature**

Client or Legal Guardian Signature: \_\_\_\_\_

Client Printed Name: \_\_\_\_\_

Guardian Printed Name if Applicable: \_\_\_\_\_

Date: \_\_\_\_\_