Myofascial Release/Healing Touch Intake Form

Date: _____ **Client:** _____

Referred by: _____ **Practitioner: Nancy Krumm Richardson, PT,**

HTCP

General Information
Address: _____
Phone: _____ Email: _____
Emergency contact (name/phone): _____
Legal guardian if under 18: _____
DOB: _____ Age: _____

Education/Occupation:

Living Situation (Marital status/pets/alone; home as supportive or stressful? Social, family, personal support?):

Military Branch and years:

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

Hobbies & interests:

Spiritual beliefs/practices/affiliations:

Is your belief a source of support to you?

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

Your perceived strengths:

Self Care

Current self-care practices (exercise, meditation, relaxation, body care, journaling, etc):

Use scale 1-10, with 10 as an extreme issue, to rate **areas of concern.** Please describe any items rated 7 or above.

___Personal Relationships

___Physical Health

___Mental Health

___Emotional Health

___Spiritual

___Work

___Finances

___Eating/Nutrition

___Addiction

___Depression

___Mood swings

___Anger

___Anxiety

___Panic or anxiety attacks

___Trauma PTSD

___Memory problems

___Personal Direction

___Headaches

___Pain

___Fatigue/lethargy

___Hormonal issues

___Allergies

___Sleeping issues

___Safety

___Major Life Change

___Other

Relevant Health History

Current overall health condition: ___Excellent   ___Very Good   ___Good   ___Fair   ___Poor

To what do you attribute your current situation, symptom or health issue?

Last physical exam:

Current health care professionals:

Health history (list medical conditions/diagnoses, with dates/years):

Hospitalizations/surgeries/accidents/injuries (date/year/complications?):

Mental health issues or diagnoses:

Mental/emotional traumas (condition/date/year):

Current prescription/over-the-counter medications/recreational drug use:

Supplements Used: __Vitamins __Minerals __Herbs __Homeopathy __Flower Essences __Other

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

Nutrition/Diet:

Elimination:

Daily water amount:

Caffeine/Alcohol/Tobacco/amount: