Transpersonal Energy Healing Therapy: Confidential Patient Intake

With Laura L. Fine

Name_____Today's date_____

Address_____City_____State_____Zip_____

Cell #_____Landline # _____ Email:_____

Occupation_____

Birthdate_____ Age_____ M___ F___ Driver's License#_____ exp date_____

Relationship status_____Spouse/Partner name & occupation_____

Names & ages of children_____

Have you ever lost/relinquished a child?

Are you or your children, adopted?

Siblings names and ages:_____

Referred by_____

What is your reason for coming? Major concern?

Other concerns?

How long have you had this condition or situation?

Is this condition getting progressively worse?
____Yes ____ No ____ Constant _____Comes & goes _____ Improving_____

How long has it been since you really felt good? _____
Please explain:

List any previous diagnoses and treatments you have received for your present condition:

What do you believe caused this condition?

History of serious physical or psychological illness:

What is your goal for our session today?

I would like the focus of our session to include:

Hands on work____ Counseling_____ Stress Management____ Coaching____

Other (please specify) _____

WOMEN ONLY: Abortions _____ Miscarriages _____ Birth Control Method _____
How is your menstruation?

List surgical operations and dates:

Broken bones, accidents and dates of incidents:

Have you ever been in therapy, healing or counseling? ____ Yes ____ No How long? _____
Are you currently in counseling? _____ What kind?

Current or past use of any prescription, non-prescription, or recreational drugs? ___yes ___no
Please list all current drugs and doses:

What other kinds of healing, therapy or support work are you getting?

My support system consists of:

Physical or emotional disorders in self/family members?

Habits(how much/how often): Alcohol use _____ Drugs (which ones) _____

Tobacco _____ Food_____ Exercise _____

Gambling _____Other_____

Comments on the above:

Is there anything else important you think I should know?

In case of emergency contact:

Name_____Relationship_____

Address _____ City _____State_____

Zipcode _____Phone_____ Email _____

I certify that the all information is true and correct to the best of my knowledge.

I Would _____ Would not _____ Like you to consult with my:

Physician ____ Therapist _____ … regarding my healing process.

My doctor's name is _____TEL #_____

My therapist's name is_____TEL #_____

Print your name _____Signature _____