

**HEALTH RENEWAL INTAKE FORM**

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| All questions contained in this questionnaire are strictly confidential  and will become part of your record. | | | | | | | | | | | | | |
| **Name** | | |  | | | | | 🞎 M 🞎 F | | | **DOB:** |  | |
| **Address:** | |  | | | | | | | | | | | |
| **Phone:** | | | |  | | | **Email:** | | | | | |  |
| **Emergency Contact:** | | | |  | | | **Legal Guardian if Under 18:** | | | | | |  |
| **Referred by:** | | | |  | | |  | | | | | |  |
| Primary reasons for considering Personal Energy Management: | | | | | | | | | | | | | |
| 🞎 | Increase relaxation | | | | 🞎 | Chronic Illness/Disease | | | 🞎 | Trauma | | | |
| 🞎 | Stress Management | | | | 🞎 | Surgery Support | | | 🞎 | Other | | | |
| 🞎 | Anxiety/Depression | | | | 🞎 | Cancer Treatment/Support | | | 🞎 |  | | | |
| 🞎 | Pain Management | | | | 🞎 | Emotional Support | | | 🞎 |  | | | |
| 🞎 | Headaches | | | | 🞎 | Spiritual Support | | | 🞎 |  | | | |
| 🞎 | Back Pain | | | | 🞎 | Major Life Change/Loss | | | 🞎 |  | | | |
| With the following scale, rate the areas of concern at this time: | | | | | | | | | | | | | |
| Blank = None 1 = Minimal 5= Moderate 10 = Extreme | | | | | | | | | | | | | |
| \_\_\_ | Personal Relationships | | | | \_\_\_ | Depression | | | \_\_\_ | Headaches | | | |
| \_\_\_ | Physical Health | | | | \_\_\_ | Mood Swings | | | \_\_\_ | Pain | | | |
| \_\_\_ | Mental/Emotional Health | | | | \_\_\_ | Anger Issues | | | \_\_\_ | Fatigue/Lethargy | | | |
| \_\_\_ | Work | | | | \_\_\_ | Anxiety | | | \_\_\_ | Hormonal Issues | | | |
| \_\_\_ | Finances | | | | \_\_\_ | Panic or Anxiety Attacks | | | \_\_\_ | Allergies | | | |
| \_\_\_ | Eating Issues | | | | \_\_\_ | Emotional Trauma/PTSD | | | \_\_\_ | Sleeping Issues | | | |
| \_\_\_ | Addiction | | | | \_\_\_ | Memory Problems | | | \_\_\_ | Other (list) | | | |
| What do you hope to experience from this session? | | | | | | | | | | | | | |
| To what do you attribute your current situation, symptom or health issue? | | | | | | | | | | | | | |
| Prior Energy Therapy Experience? 🞎 Yes 🞎 No | | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- |
| Current self-care practices (exercise, meditation,relaxation, body care, journaling, etc.): | | | | | | |
| Sleep quality and sleep aid usage: | | | | | | |
| Daily water amount: | | | | | | |
| Caffeine/alcohol/tobacco/drug usage/amount: 🞎 Alcohol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Drug Use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Tobacco \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **Marital status:** | 🞎 Single 🞎 Partnered 🞎 Married 🞎 Separated 🞎 Divorced 🞎 Widowed | | | | | |
| Living Situation (i.e., pets, alone, home as respite, stressful, etc.) | | | | | | |
| **Education/Occupation:** | |  | | | | |
| Hobbies and Interests: | | | | | | |
| Spiritual beliefs/practices/affiliations: | | | | | | |
| **Is your belief of support to you?** | | |  | **Word(s) you use for Higher Power:** |  | |
| Is there anything else you want me to know? | | | | | | |
| Any questions about Health Renewal? | | | | | | |