Welcome to Infinity Tree Energy Healing and Wellness

Healing Session Intake Form

Welcome,

Prior to your initial visit, please complete the following questions to the best of your ability so we can make the most of our time together. Before your appointment, please contact me if you have any questions or concerns. When you have completed this questionnaire, read and sign the service agreement. Please bring it with you to your scheduled appointment. This form will remain **confidential**.

Today's Date: _____ First and Last Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ____

Phone #: ( ) -_____ Cell #: ( ) -_____

E-Mail Address: _____

Emergency Contact (name and phone #): _____

Primary Physician (name and phone #): _____

Therapist(s) (name and phone #): _____

How did you hear about my practice? _____ If referred, by whom? _____

What would you like help or support with? What do you hope to achieve? _____

_____

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_____

List any traumatic/life changing events that have happened in your life (death, divorce, loss, illness, abuse, accidents, etc.). _____

_____

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_____

What do you want to create in your life? What do you envision? What are your interests and passions?

_____

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_____

Current and Past Medical History: (please circle all that apply)

Muscular: back pain, neck pain, muscle pain, (where) _____

Autoimmune: Lyme's Disease, fibromyalgia, allergies, arthritis, cancer (type), _____

Digestive: constipation, diarrhea, acid reflux, ulcers, other: _____

Neurological: seizures, dizziness, migraine, head injury, stroke, neuropathy, other: _____

Respiratory: asthma, trouble breathing, COPD, other: _____

Cardiovascular: heart disease, low/high blood pressure, heart attack, other: _____

Reproductive: endometriosis, pregnancy, miscarriage, abortion, cyst, fibroid, other: _____

Endocrine: diabetes, hyperthyroid, hypothyroid, adrenal insufficiency, other: _____

Infectious Disease: HIV/AIDS, hepatitis, MRSA/VRE, other: _____

Ears/Nose/Throat: headaches, earaches, jaw pain, sinus problems, other: _____

other: _____

Mental: depression, anxiety, panic attacks, mood swings, psychosis, substance abuse, eating disorders.
Have you ever been hospitalized for psychiatric reasons? __yes __no

How do sleep, diet, and exercise play a role in your symptoms? _____
_____
_____

Daily intake of: Caffeine _____, Alcohol _____, Tobacco _____, Sugar _____, Recreational drugs _____.

What factors might be contributing to your current situation? Do any of the above issues interfere with your ability to live the life you desire? _____
_____
_____

What is your birth order (youngest, oldest, only child)? Did you have any traumas at birth? What were your interests as a child (outdoors, arts, reading)? _____
_____
_____

Do you have a spiritual practice? How do you belong in the universe? What is your purpose? _____
_____
_____
_____
_____