

Creative Wellness

8 Court House S- Dennis Road
Cape May Court House, NJ 08210
Phone: 609-463-0999 ~ Fax: 609-778-1201

Internal Use Only: <input type="checkbox"/> Ref T.Y.
<input type="checkbox"/> M.S.
<input type="checkbox"/> Eso. <input type="checkbox"/> F <input type="checkbox"/> Pat.
<input type="checkbox"/> E/W <input type="checkbox"/> F <input type="checkbox"/> Xmas

How you heard of us: _____

HEALING TOUCH - Client Information

Name: _____ Telephone: _____ Email: _____
Address: _____ Cell Phone: (____) _____
Date of Birth: _____
Age: _____
In Case of Emergency: _____ Telephone: _____

General & Medical Information

Occupation: _____ Male Female Physician: _____

Living Situation (marital status, pets, alone; home as respite or stressful):

Military Branch and years:

What do you hope to experience from this session?

Prior Energy Therapy / HT experienced?

Current overall health condition: __Excellent __Very Good __Good __Fair __Poor

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

Your primary reasons for seeking Healing Touch are:

- | | | |
|---|--|---|
| <input type="checkbox"/> Increase relaxation | <input type="checkbox"/> Chronic Illness / Disease | <input type="checkbox"/> Emotional Support |
| <input type="checkbox"/> Stress Management | <input type="checkbox"/> Surgery Support | <input type="checkbox"/> Spiritual Support |
| <input type="checkbox"/> Anxiety / Depression | <input type="checkbox"/> Cancer Treatment Support | <input type="checkbox"/> Major Life Change / Loss |
| <input type="checkbox"/> Pain Management | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Other _____ |

With the following scale, rate the areas of concern at this time:

Blank = None 1 = Minimal 5 = Moderate 10 = Extreme

- | | | |
|--|---|---|
| <input type="checkbox"/> Personal Relationships | <input type="checkbox"/> Depression | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Physical Health | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Mental/Emotional Health | <input type="checkbox"/> Anger issues | <input type="checkbox"/> Fatigue / lethargy |
| <input type="checkbox"/> Work | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hormonal issues |
| <input type="checkbox"/> Finances | <input type="checkbox"/> Panic or anxiety attacks | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Eating issues | <input type="checkbox"/> Emotional trauma / PTSD | <input type="checkbox"/> Sleeping issues |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Other (list) |

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

Hobbies & interests:

Spiritual beliefs / practices / affiliations:

Is your belief a source of support to you?

Word(s) you use for Higher Power?

Relevant Health History

Primary physician or health care professional:

Last physical exam:

Other types of health care professionals you see:

Current or chronic medical conditions, diagnosis, or treatments with dates:

Mental health issues or diagnoses:

Hospitalizations / surgeries (condition/date/year):

Significant physical or emotional traumas (condition/date/year):

Current prescription or over-the-counter medications:

Supplements Used:

Vitamins Minerals Herbs Homeopathics Flower Essences Other

Sleep quality & sleep aid usage:

Nutrition

Daily water amount:

Caffeine / Alcohol / Tobacco / Drug Usage / amount:

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Is there anything else you want me to know?

Any questions about me or HT?

I understand that the massage/bodywork and energy healing I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes or techniques may be adjusted to my level of comfort. I further understand that massage, bodywork and energy healing should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork and energy practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork and energy therapies should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

A cancellation after 3PM the day prior to your appointment time or not showing up for your appointment will result in you being charged the full appointment fee.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork, or energy therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____