THE HEALING COMPANY LTD
HEALING THE HUMAN ENERGY FIELD

CLIENT HISTORY

(Confidential – for Practioner's use only)

Name _____ Date _____

Address _____

_____

Phone – home_____ Mobile / work _____

Email _____ DOB _____

Occupation _____ Referred by _____

Relationship status _____ # Children _____ Height _____ Weight _____

Reason for visit _____

_____

Current medications _____

Current complementary therapies / supplements _____

Eating habits / diet _____

Amount daily intake: Water _____ Caffeine _____ Alcohol _____ Cigarettes _____
(or tobacco)

Excercise routine: _____

HISTORY

Please mark the following areas of diseases or symptoms as 'C' for current, 'P' for past, or 'CH' for chronic

EMOTIONAL / PSYCH	**CARDIOVASCULAR**	**NEUROLOGICAL**	**REPRODUCTIVE**
Depression	Angina	Epilepsy	STDs (type)
Eating disorder	Heart attack	Dizziness	Endometriosis
Mood swings	Heart failure	Insomnia	Pregancies (# & 'C')
Substance abuse (type)	Hypertension	Migraines	Miscarriage (#)
AUTO IMMUNE	Stroke	**RESPIRATORY**	Abortion (#)
AIDS / HIV	**MUSCULO-SKELETAL**	Bronchitis	**OTHER** (specify):
Allergies	Arthritis	Emphysema	
Cancer	Back pain	Pneumonia	
Fatigue	Carpal tunnel	Tuberculosis	
Fever (chronic)	Gout	**DIGESTION**	
Fibromyalgia	Skin disorder (type)	Constipation (chronic)	
Fungal infections (type)	**ENDOCRINE**	Diabetes	
Herpes (type)	Adrenal insuf.	Diarrhea (chronic)	
Lyme Disease	Pituitary dysf.	Gastritis	
Mononucleosis	Hyperthyroid	Hepatitis	
ENT	Hypothyroid	Hypoglycaemia	
Earaches (chronic)	**URINARY**	Jaundice	
Headaches	Bladder infection	Liver disorder	
Jaw pain	Kidney stones	Ulcers	

Please mark the following areas of diseases or symptoms as 'C' for current, 'P' for past, or 'CH' for chronic

Crying spells	Change in sleep	Family problems	Angry outbursts
Loneliness	Relationship problems	Increased nervousness	Eating changes
Social problems	Seeing things	Headaches	Work problems
Trouble concentrating	Sadness	Hearing things	Change in sexual activity
Suicidal	Feeling out of control	Homicidal	Unmotivated
Loss of trust in others	Financial problems	Panic attacks	Weight loss/gain
Forgetfulness	Violent feelings	Increased alcohol/drug use	Confusion

Please list any traumatic or life-threatening events that have occurred in your life, and when they happened:

_____

_____

_____

_____

What do you hope for, and what are your expectations from this session and long term?

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_____

Is there anything else you want me to know?

_____

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