Joanie DelaGarza, RN

 **Harmonizing Touch Healing Therapies**

**Craniosacral · Healing Touch · Reiki · Light Therapy**

 Healing Touch Certified Practitioner (HTCP)

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*Revitalizing Body, Mind, & Spirit*

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian (If under 18)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ok to receive my monthy blog “Living in Harmony” Yes\_\_\_\_No\_\_\_\_\_

Previous experience with Craniosacral, Healing Touch, Reiki, etc. Other modalities?

Living Situation: (married, single, roommates, pets, stressful or place of respite?)

Current overall health condition? \_\_\_Excellent\_\_\_\_Very Good\_\_\_\_Good\_\_\_\_Fair\_\_\_\_Poor

Reasons for seeking a treatment session?

\_\_\_Relaxation \_\_\_Chronic Illness \_\_\_Emotional Support

\_\_\_Stress Management \_\_\_Surgery Support \_\_\_Spiritual Support

\_\_\_Anxiety/Depression \_\_\_Cancer Support \_\_\_Major Life Change/Loss

\_\_\_Pain Management \_\_\_Back Pain \_\_\_Headaches

\_\_\_Rehabilitation \_\_\_Trauma \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 \_\_Allergies \_\_Panic/Anxiety Attacks

\_\_Eating issues \_\_Sleeping Issues \_\_Emotional Trauma/PTSD

\_\_Addiction \_\_Memory Problems \_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalizations/Surgeries (condition/date)

Current or chronic medical conditions, diagnosis, treatments (dates if possible).

Have you had any traumatic experiences in the past: car accidents, falls, PTSD, physical or verbal abuse, extreme stress? If yes, which one/s?

What do you believe is the reason for your current health issue?

Medications/Supplements (please list)

Prescription Meds Over-the-Counter medicines Supplements

Primary Physician: Date of last physical:

Other Healthcare Professionals:

Do You Use: (type/frequency)

alcohol caffeine tobacco recreational drugs

Nutrition: (quality of diet/special diet) Water intake: glasses per day\_\_\_\_\_\_\_\_\_

Sleep Patterns: Insomnia/sleep aids? Elimination: regular constipation

Relaxation/Self Care practices:

exercise meditation relaxation journaling hobbies other

Additional information that would be helpful to know: