Winston Salem Healing Clinic **Date: _____**
Confidential Intake Form

Name: _____ DOB: _____
Address: _____
Phone Number(s): _____
Email: _____
Purpose of Visit: _____
_____
_____

History of previous health/wellness events and dates/onset of illness, injuries, traumas, surgeries: _____
_____
_____
_____
_____

Are you currently receiving healing work? If so, what kind? _____
_____
_____
_____

Medications, OTC Medications/Supplements (List & describe reason for taking): _____
_____

Exercise, Sleep Patterns and Nutritional Support: _____
_____
_____
_____
Current Stress Level: Please indicate by number (0=low; 10 =high) _____

Emergency Contact:
Name: _____Phone: _____ Relation: _____

Would you like to be on our mailing list for future clinics? _____

Please contact us with any further questions. Thank you!