Quantum-Touch® *energy healing* Session Intake Form

Name:_____ *Phone:*_____

Address:_____

When were you last seen by a healthcare practitioner (medical or otherwise)? _____

How did you hear about **Quantum-Touch**? _____

What are the most important concerns I can help you with today, and how severe are they?
Please list your concerns and then circle how you rate their intensity, using a scale of 0 to 10
0 = barely noticeable and 10 = very severe

1) _____										
0	1	2	3	4	5	6	7	8	9	10
2) _____										
0	1	2	3	4	5	6	7	8	9	10
3) _____										
0	1	2	3	4	5	6	7	8	9	10
4) _____										
0	1	2	3	4	5	6	7	8	9	10

Anything you would like to add?