



Heimann Counselling and Healing – Intake Form

Client ID: _____

Name: _____ Home-phone: _____

Postal Address: _____ Can we leave messages on your home voicemail?

City: _____ Yes No

Postal Code: _____ Work-phone: _____

Date of Birth: _____ E-mail: _____

How did you hear about HCH? _____

Living situation:

Are you living with a partner? Yes No Do you have children? Yes No

Do you have pets? Yes No Ages of Children: _____

Religious/Spiritual belief: _____ Occupation: _____

I, the undersigned, have read and give consent to the following conditions:

Heimann Counselling and Healing (HCH) maintains the strictest of confidentiality in order to protect client information. Confidentiality is broken only when written permission is granted by the client(s) or when the Counsellor/Healing Practitioner believes a person (e.g. client or child of a client) is in life-threatening danger, or when mandated by law (e.g. subpoena by a court of law). I am aware that I can request HCH’s Privacy Policy either in writing at any time or online at www.heimann.ca.

It is the normal practice of HCH to consult with other professional Counsellors/Healing Practitioners in order to improve the quality of treatments. No names are used during these consultations.

Counsellor/Healing Practitioner of HCH do not diagnose or prescribe medication for medical or psychological conditions.

Energy Healing techniques like Energy Massages, Healing Touch or Reiki are primarily a vehicle for holistic self-development, offering stress reduction and enhancing the client’s total well-being. Healing occurs by the client’s acceptance of energy offered by the Healing Practitioner. Having read the preceding information, I accept any physical or emotional results of the healing session and do not hold the Healing Practitioner responsible for any such effects.

I understand that HCH requires a **24-hour cancellation notice**. Otherwise a full payment for the session has to be made. I understand that I may elect to end counselling/healing at any time.

(Date)

(Signature)

Medical/Health History (please explain what applies):

Abuse	Alcohol/ Drug Problems	Allergies	Anxiety	Asthma
Back problems	Bronchitis	Cancer	Circulation	Clot
Colon	Depression	Diabetes	Digestive	Eating Disorder
Gall Bladder	Headaches	Hearing	Heart	Heart Attack
High Blood Pressure	Kidneys	Liver	Lung	Reproductive Organs
Seizures	Sexual Abuse/Assault	Stomach	Stroke	Surgeries
Thyroid/ Hormonal	Trauma/ Serious Accident	Urinary Tract	Vision	Weight Problems

Other: _____

Health Care Professionals:

Counsellor/Therapist: _____ last seen: _____

Physician/Naturopath: _____ last seen: _____

Others: _____

Current Medication/Supplements (please explain what applies):

Over the Counter Medicine _____ Supplements _____

Prescription Medicine _____ Herbs _____

Homeopathic Medicine _____ Remedies _____

Vitamins _____ Other _____

Stress experienced through... (Use scale from 0 (no stress) to 10 (extreme)):

Illness _____ Work _____ Relationship _____ Finances _____ Loss _____

What do you do to relax? Physical activities / Meditation etc. (Please explain):

Reason for Coming: _____

Personal Goals: _____