Fragrance Healing Ministries

Intake Form

Name _____ Date _____

Address _____ Emergency contact _____

Phone _____ Phone _____

Relationship to you: _____

**Please answer the questions below.

How did you learn about us?

Have you received Healing Prayer before?

Are you currently working with another Healing Prayer Minister/Ministry?

Have you been in counseling before?

Are you currently working with a counselor/therapist?

Psychiatrist?

If yes, how many times per week? How many hours?

Why did that relationship end?

What did you like most about your therapist?

What did you like least about your therapist?

Are you taking any psychiatric medications?

Would you please share what in your life has made you seek out healing at this time?

What areas of your life are you seeking to change?

What are your goals for your own healing?

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Personal History

**Please mark any of the following conditions you or your children may currently have.

- ☐ Autism/ASD/Asperger's
- ☐ Pandas
- ☐ Pans
- ☐ Adhd/Add
- ☐ BiPolar
- ☐ Depression
- ☐ Anxiety
- ☐ Seizures
- ☐ Lyme
- ☐ Thyroid Disorder
- ☐ Food Allergies/Sensitivities
- ☐ **Childhood Trauma**
- ☐ TMJ
- ☐ Bowel Issues
- ☐ Constipation
- ☐ Diarrhea
- ☐ EDS
- ☐ POTS
- ☐ CIRS
- ☐ MCAS
- ☐ ODD
- ☐ Sensory Processing Disorder
- ☐ Grief process
- ☐ Grief Proscess
- ☐ ODC
- ☐ Sleep Issues
- ☐ Chronic pain
- ☐ Fybromyalgia
- ☐ Chronic Fatique
- ☐ Vaccine-Injury
- ☐ Current Mold Exposrure
- ☐ Past Mold Exposure s
- ☐ Other Mental Disorders
- ☐ **Other Physical Conditions**

List any other physical, mental, spiritual, behavioral conditions in your family, your family of orgin, birth or adoptive family not mentioned.

- ☐ Divorced
- ☐ Widowed
- ☐ Loss of a child through death
- ☐ Adoption (placed for or received)
- ☐ Child with Chronic Illness
- ☐ Miscarriage
- ☐ Early Infant death
- ☐ Special Needs Child