The Healing Place

Confidential Assessment /Interview

Personal Information

Last Name: _____ First Name: _____MI: ___

Date of birth: _____ Age: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Faith Related

Are you a born again Christian? Yes_____ No _____ Date of conversion: _____

Are you a member of a church? Yes ____ No _____

Is so, where? _____ How long have you been a member? _____

How often do you attend church? Weekly _____ Monthly_____ Occasionally _____

Do you own a Bible? Yes____ No ____ Version you read: _____

How often do you read the Word? Daily ___Once a week___ Occasionally_____

How often do you spend time in prayer? Daily _____ Weekly ____ Occasionally ___

What do you believe about healing?

_____

_____

_____

What do you expect God to do for you through The Healing Place?

_____

_____

_____

Medical Information

Name of personal physician/clinic_____ Phone #: _____

Medical record available: Yes _____ No_____ Hospital of choice: _____

Medical Diagnosis - the condition which brought you to The Healing Place

Please describe:

Sensory assessment – please check all that apply to you

____ Vision impairment
____ Glasses/contact lenses
____ Blind
____ Hearing impairment
____ Hearing aid

Can you read? ___ Yes ___ No

Health habits

Do you smoke or use tobacco in any form? ___ Yes ___ No
Do you drink alcohol in any amount? ____ Yes ____ No

Any other information that might be helpful for the staff to know

_____

_____

_____

_____

_____

For healing staff: _____ accepted ____ not accepted as this time

Intake interviewer: _____ Signature: _____