Sound Healing and Holistic Therapy
Intake Form

Name:	Date:	Occupation:
Address:	Phone:	Date of Birth:
City: State:	Zip Code:	Email:
Emergency Contact Name:		Phone:
How did you hear about us:		Referral Name:

GENERAL HEALTH
1. Methods of relaxation that you practice in your daily life:
2. hat is the main source of stress in your life?
3. Do you have any sensitivity to sound or vibration? ☐ Yes ☐ No
4. Do you have any difficulty lying on your front or back? ☐ Yes ☐ No Please explain which s ide and the issue?
5. Please list any accidents or surgeries in the last 2 years
6. Do you have any metal implants, a pacemaker or body piercings?
7. List the medications you are currently taking:

VIBRATIONAL SOUND THERAPY	GOAL FOR YOUR VST SESSION
Have you ever had a singing bowl therapy before? If so, when?	☐ Relaxation
Do you have any allergies?	☐ Pain Relief
Is there any area of your body you do not want the bowls to be placed?	☐ Stress reduction

HEALTH HISTORY				
☐ Heart Condition	☐ Psychiatric Disorder	☐ Herpes/Shingles	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Numbness/Tingling	☐ Sinus Problems	☐ Allergies	☐ Chronic Pain	☐ Varicose Veins
☐ Rashes	☐ Jaw Pain/TMJ	☐ Blood Clots	☐ Constipation	☐ Sprains/Strains
☐ Diabetes	☐ Gas/Bloating	☐ Headaches	☐ Arthritis	☐ Spasms/Cramps
☐ Broken/Fractured Bones	☐ Pregnancy (___ weeks)	☐ Fatigue/Sleep Disorder	☐ Depression/Anxiety	☐ Cancer
☐ Other (explain):			☐ Metal in body	

1. Rate Stress Level before Session (on a scale from 1 to 10 with 1 being low and 10 being highest)
2. Rate Pain Level before Session (on a scale from 1 to 10 with 1 being low and 10 being highest)
3. Rate Anxiety Level before Session (on a scale from 1 to 10 with 1 being low and 10 being highest)

It is my choice to receive Sound Healing and Holistic Therapy vibrational sound therapy and I understand that the practitioner will be using gentle sound and vibration during the sessions on/around me. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update my practitioner of any changes to my health status. I understand that practitioners certified by Life Changing Energy Certified Healers do not diagnose illness, disease, or physical or mental disorders, nor do they prescribe medical treatments or pharmaceuticals. I acknowledge that these sessions are not a substitute for medical examination or diagnosis, and that is recommended I see a primary health care provider for those services. I understand that I alone am responsible for informing my

primary health care provider I am receiving these sessions and inquiring as to whether or not they may adversely affect my current health condition.

Signature ____________________ Date ____________________

Privacy Policy: No information about any client will be discussed or shared with any third party without written consent of the client or parent/guardian if the client is under 1 .

Sound Healing and Holistic Therapy

CLIENT CONSENT FOR SOUND HEALING AND HOLISTIC THERAPY

I, ____, understand that Sound Healing and Holistic Therapy provides a gentle, sound based approach to health and healing that can potentially assist my body in its natural ability to heal. I fully acknowledge and understand that this is accomplished through the use of light contact and/or no contact touch. I acknowledge that long term imbalances or dis-ease in my body sometimes requires multiple sessions in order to facilitate the level of relaxation needed by the body to heal itself.

I understand that Sound Healing and Holistic Therapy is not intended to replace any currently prescribed medical treatments as ordered by my physicians, nor any other medical care I have, or may be advised to seek by them.

I understand that the practitioner will neither diagnose any medical condition, nor prescribe for any condition that I might have, nor does that practitioner make any specific claims regarding results from the sessions that I receive. I agree that it is my responsibility to consult a licensed medical practitioner for any physical or mental complaints I may have.

I understand that all client information and records are treated in a confidential manner. My experiences during these sessions are confidential subject to the usual exceptions governed by state or federal laws and regulations.

I, or my representative(s) agree to fully release and hold harmless Sound Healing and Holistic Therapy and practitioners therein from and against any and all claims or liability of whatsoever kind or nature arising out of, or in connection with, my session (s).

I give my consent to receive Sound Healing and Holistic Therapy sound based vibrational therapy.

Signature ____

Date ____