



## Sound Therapy Intake Form and Waiver

### Personal Information:

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation/s: \_\_\_\_\_

Physical Activities: \_\_\_\_\_

### Emergency Contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

### Sound and Medical Information:

Have you had a professional Sound Therapy Session before? Y \_\_\_\_\_ N \_\_\_\_\_

Level of stress: (5 - Highest, 1 - Lowest) \_\_\_\_\_

What is the main source of stress in your life? \_\_\_\_\_

Do you have sensitivity to sound or vibration? Y \_\_\_\_\_ N \_\_\_\_\_

Do you have difficulty lying on your front or back? Y \_\_\_\_\_ N \_\_\_\_\_

Please explain: \_\_\_\_\_

Any hearing issues, hearing aids, or any injury associated with the ear? Y \_\_\_\_\_ N \_\_\_\_\_

Any implants or pacemakers etc.? Y \_\_\_\_\_ N \_\_\_\_\_

Are you Pregnant? \_\_\_\_\_ If YES, how far along are you? \_\_\_\_\_ weeks.

### Please check all that apply:

Lymphatic conditions

Diabetes

Tendonitis or Bursitis

High Blood Pressure

Blood Clots

Varicose Veins

Headaches or Migraines

Joint Issues

Bone fracture

Osteoporosis

Recent Injury

Numbness or Tingling

If needed, please explain any of the above: \_\_\_\_\_

OTHER SIDE →

Please review and initial the following statements:

\_\_\_\_\_ If I experience pain or discomfort during the session, I will immediately inform my therapist so that any pressure or techniques applied can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

\_\_\_\_\_ I understand that the services offered today are not a substitute for medical care. I also affirm that I have notified my therapist of all known medical conditions and injuries. I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist part should I forget to do so.

\_\_\_\_\_ Sound Therapy is contraindicated for certain medical conditions. I affirm that I have discussed all my know medical conditions wit the Therapist, and completed the information on this consent honestly. I understand that I should see a physician or qualified medical specialist for any mental or physical ailment of which I am aware. I agree to keep the Therapist updated as to any changes in my medical/physical conditions that might affect my ability to safely receive my Sound Session.

\_\_\_\_\_ By signing this release, I herby waive and release Sound Therapy of the Pacific Northwest and my therapist from any and all liability, past, present and future relating to Sound Therapy of the Pacific Northwest.

\_\_\_\_\_ I understand that should I cancel or reschedule an appointment less that 24 hours before the scheduled time or don't show up to the appointment, I am subject to a fee equal to the full cost of the missed appointment. If the appointment was booked under gift certificate, or package, it will be voided or redeemed in lieu of the fee. I also, understand all sales are final, no refunds.

\*In general, sound therapy is done while fully clothed. This is your session and you should be as comfortable as possible, ware comfortable clothes.

\*Sound Therapy is a therapeutic, professional service. Inappropriate or sexual conduct of any kind, initiated by any party will not be tolerated. If uncomfortable for any reason, the client or therapist may ass to end the session, and the session will end.

I have received this policy statement and have read and agreed to all of the policies therein:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_