INTAKE APPRAISAL – SOUND BALANCING

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. What is the main source of stress in your life?					
3. Do you have any sensitivity to sound or vibration?					
4. Do you have any difficulty lying on your front or back? 🛛 Yes 🛛 🗆 No Please explain					
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 BALANCING & VIBRATIONAL REPATTERNING GOAL FOR YOUR SESSION					SESSION
Have you ever had a singing bowl, gong, tuning fork or sound immersion session before? If so, when?				Relaxation	
Do you have any allergies?				Pain Relief	
Is there any area of your body you do not want the instruments to be placed?				Stress reduction	
I hereby give permission to have instruments placed on my body.				□ Yes No□	
□ Heart Condition	Psychiatric Disorder	□ Herpes/Shingles	🗆 High	Blood Pressure	Low Blood Pressure
□ Numbness/Tingling	□ Sinus Problems		Chro	nic Pain	□ Varicose Veins
□ Rashes	□ Jaw Pain/TMJ	□ Blood Clots	Const	tipation	□ Sprains/Strains
□ Diabetes	□ Gas/Bloating	□ Headaches	□ Arthr	itis	□ Spasms/Cramps
□ Broken/Fractured Bon	s 🗆 Pregnancy (weeks) 👘 Fatigue/Sleep Disorder 👘 Depression/Ar		ession/Anxiety	Cancer	
Other (explain):					
***I HAVE REVIEWED CONTAINDICATIONS: WHEN NOT TO USE SOUND INSTRUMENTS OR SOUND BALANCING ***I UNDERSTAND AND GIVE PERMISSISON FOR PRACTITIONER TO TOUCH AND PLACE INSTRUMENTS ON MY 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 Vibrational Sound Balancing – Vibrational Repatterning and I understand that the practitioner will be using gentle sound and vibration during the sessions on or around me as well as possibly use touch. 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 Melissa Zollo is certified by the Vibrational Sound Association, Sound Academy, and she does not diagnose illness, disease, or physical or mental disorders, nor does she prescribe medical treatments or pharmaceuticals. I acknowledge that these sessions are not a substitute for medical examination or diagnosis, and that it 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 that 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 underage.