VIBRATIONAL SOUND ASSOCIATION

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. Rate your level of stress: (5 = highest, 1= lowest) ☐5 ☐4 ☐3 ☐2 ☐1
2. What is the main source of stress in your life?
3. Do you have any sesitivity to sound or vibration? ☐ Yes ☐ No
4. Do you have any difficulty lying on your front or back? ☐ Yes ☐ No Please explain which side 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):				

1. Are you currently under the care of a doctor or physician?
2. Have you informed your primary care provider that you are receiving VST session(s)?
3. Are you currently using any additional techniques to manage stress?

It is my choice to receive 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 the Vibrational Sound Association 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 18.