# CLIENT INTAKE FORM FOR SOUND HEALING SESSION

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| Full name (including the name you wish to be addressed as, if different) | |
| Full Address | |
| Home telephone number | |
| Cell number | |
| E-mail address | |
| Date of birth | |
| Gender | |
| Name and address of your physician / GP | |
| Are you currently taking any medication (Please use additional sheets if required) | YES / NO (if yes please give details) |
| Please give details of recent and relevant medical treatment, operations or family history etc (Please use additional sheets if required) | |
| Do you have Epilepsy? | YES / NO (if yes please give details) |
| Are you pregnant or trying to be pregnant? | YES / NO (if yes please give details) |
| Do you have any metal medical implants | YES / NO (if yes please give details) |
| Do you have a deep vein thrombosis in the leg or known thrombi? | YES / NO (if yes please give details) |

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| Do you have any open wounds? | YES / NO (if yes please give details) |
| Do you have any acute inflammations and tumours? | YES / NO (if yes please give details) |
| Have you recently had any surgery? | YES / NO (if yes please give details) |
| Do you have carotid atherosclerosis? | YES / NO (if yes please give details) |
| Do you have eczema? | YES / NO (if yes please give details) |
| Do you have any diseased veins? | YES / NO (if yes please give details) |
| Do you have any inflammatory skin disorders? | YES / NO (if yes please give details) |
| Do you have any other inflammatory processes generally associated with fever? | YES / NO (if yes please give details) |
| Do you have a cardiac pacemaker, artificial heart valves, defibrillator or cardiac arrhythmias | YES / NO (if yes please give details) |
| Do you have a shunt? | YES / NO (if yes please give details) |
| Do you have a stent? | YES / NO (if yes please give details) |
| Do you have a deep brain stimulation device (DBS)? | YES / NO (if yes please give details) |
| Have you had whiplash in the last 3 days? | YES / NO (if yes please give details) |
| Please sign to confirm that all information given is accurate and correct at the time or writing | |
| Date signed | |

CLIENT RECORD CONTINUED

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| How would you describe your diet? | |
| How would you describe the level and types of exercise you do? | |
| How would you describe your sleep patterns? | |
| Do you suffer from stress - and if so are there any triggers and how do you deal with them? | |
| How would you describe your lifestyle including any leisure activities or hobbies etc? | |
| Do you smoke - if so, for how long and how many per day? | |
| Do you drink alcohol - if so how often and how much approximately? | |
| What would you say prompted you to come for this treatment? | |
| What would you like to get out of the treatment?<br><br>If pain reduction is indicated, benchmark the current level of pain on a scale of 1 - 10 with 10 being the highest the client has ever experienced. | |
| Is there anything else that you think might be relevant to the treatment? | |
| Have you had any other complementary therapies or sound therapy. If so which and give details? | |

**SOUND HEALING CONFIDENTIALITY CONSENT FORM & WAIVER**

I, _____ agree to participate in receiving Sound Healing from Carolyn Tylenda, Sound Healer (the "Practitioner"). I understand that these sessions are confidential. I agree to be responsible for all financial payments. While there are many reports of stress reduction and general improvement of emotional, spiritual and physical well being, Sound Healing treatment is not intended, nor implied, to be a substitute for medical treatment and I understand that I will have to seek medical treatment for any physical or mental ailment. Sound Healing is not a medical treatment and I acknowledge and agree that the Practitioner is not liable for any damages or injuries resulting from the treatment and I release the Practitioner from all claims relating to such treatment.

_____ _____

Signature of Client Date

_____ _____

Carolyn Tylenda, Sound Healer Date