# Sonic Facelift Scottsdale Intake

## Client Information

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Address: _____

City: _____ State: _____ Zip: _____

Mobile: _____

Preferred Contact Method: Phone ☐ Text ☐ Email ☐

Email Address: _____

How did you hear about Sonic Facelift Scottsdale? _____

## Health and Lifestyle History

Please describe the main reasons for seeking a session or treatment today:

_____

_____

_____

How long have you experienced this condition? _____

What seemed to be the initial cause? _____

Do you have a pacemaker/other electrical implant? _____

Are you pregnant? _____ If yes, what trimester? _____

Please list any injuries, illnesses, or surgeries (past or present):

_____

_____

List any significant traumas, accidents, or childhood illnesses:

_____

_____

What time do you retire nightly? _____ At what time do you wake? _____

Do you smoke cigarettes? _____ How many per day? _____

How much alcohol do you drink per week? _____

How much coffee, tea or chocolate do you have per week? _____

Describe any non-medical drug use _____

_____

Please describe any digestive difficulties _____

_____

How much water do you drink daily? _____

How would you describe your diet? _____

Please list any occupational stressors (chemical, physical, psychological, etc.)

_____

What are your current physical activities, diet, and relaxation practices?

_____

_____

Do you have any allergies (food, environmental, or chemical)?

_____

Are you currently taking any prescription or natural medications?

_____

_____

Have you been diagnosed with any of the following:

Heart disease _____ Diabetes _____ Hepatitis _____ Hypertension _____

Rheumatic fever _____ Thyroid dysfunction _____ Seizures _____

Migraines_____ Cancer ___ (type) _____ Stroke _____

Asthma _____ (Other) _____

Please check the elemental conditions you have experienced in the last 6 months. If the experience has continued to the present, circle it.

| *Wood* | *Fire* | *Earth* | *Metal* | *Water* |
|---|---|---|---|---|
| __ headache | __ dry scalp | __ indigestion | __ bronchitis | __ hearing loss |
| __ migraines | __ skin rash | __ flatulence | __ asthma | __ dizziness |
| __ ringing ears | __ cysts, tumors | __ food allergies | __ shallow breath | __ lower back pain |
| __ poor eyesight | __ ear infections | __ stomach ache | __ cough | __ neck pain |
| __ dry eyes | __ lymphatic swelling | __ diarrhea | __ sinus congestion | __ sinus congestion |
| __ eczema | __ hot palms/soles | __ anemia | __ nasal infections | __ edema |
| __ shingles | __ palpitations | __ halitosis | | __ dark below eyes |
| __ warts | __ bitter mouth | __ sores in the mouth | | __ emotional |
| __ nervous | __ aversion to heat | __ heartburn | | __ hair loss |
| __ irritability | __ gum problems | __ strong appetite | | __ easily gets cold |
| __ constipation | __ nosebleed | __ nausea | | __ frequent urination |
| __ hemorrhoids | __ facial redness | __ weak appetite | | __ perspires easily |
| __ ulcer | __ itching/ burning skin | __ abdominal bloating | | __ weak legs/knees |
| __ vomiting | __ hot hands/feet | __ low body weight | | __ weight loss |
| __ gallstones | __ thirst | | | __ loose teeth |
| __ fullness below ribs | __ vivid dreams | | | __ low sex drive |
| __ tightness of shoulders/neck | __ dark urine | | | __ hyper/ hypo-thyroidism |
| __ insomnia; 11 pm-3 am | __ night sweats | | | __ diabetes |

Other symptoms:

__ fatigue __ arthralgia __ sciatica/ nerve pain __ cold hands/feet __tendonitis __bursitis

Female syndromes:

| | | | | |
|---|---|---|---|---|
| __ vaginal infection | __ yeast infection | __ breast lumps | __ irregular periods | __ + PAP |
| __ genital burning | __ urinary tract infection | __ cramps | __ hemorrhoids | __ ovarian cysts |
| __ PMS | __ anal fissures | __ genital herpes | __ infertility | __ pelvic inflammation |
| __ excessive bleeding | __ # of pregnancies | __ # of children | | |

Male syndromes:

| | | | | |
|---|---|---|---|---|
| __ prostatitis | __ burning urination | __ incontinence | __ nocturnal emissions | __ impotence |
| __ premature ejaculation | | | | |

## Reiki

Have you ever had a Reiki session before? Yes _____ No _____

If yes, when was your last session? _____

Would you like aromatherapy during your session? _____

Scents you love: _____

Scents you hate: _____

Light touch or no touch? _____

## Light Therapy

Have you ever had a LED or Far Infrared Light therapy before? Yes _____ No_____

If yes, when was your last session? _____

## Sonic Facelift™

Describe your daily facial care program _____

_____

_____

What would you like to change and what would you like to honor in your face?

_____

_____

_____

## Psychospiritual Insights

This section invites gentle reflection on physical, emotional, and ancestral patterns. Please check or note any statements that feel true for you or that speak to patterns you wish to explore.

**1.**

_____ I have muscular spasms in the neck and back due to stress and incessant inner chatter.
_____ I have a hoarse, blocked throat from fear of speaking my truth.
_____ I have a chronic sinus headache because I do not take the time to experience the beauty of life.
_____ There is manic depression, childhood epilepsy, seizures, or there are mentally disturbed people in my family.
_____ I have, or have had, personal psychospiritual or mental problems.
_____ There are psychospiritual imbalances, or mental illness, that I am carrying for a family member or ancestor.

**2.**

_____ I have hypo- or hyper-thyroid conditions, a goiter, mass, lumps or swelling in the throat area.
_____ I have an inability to ask for what I want and a feeling of resentment from pleasing others.
_____ I am a caretaker and have issues of co-dependence.
_____ I long to claim the creative power of my own true voice.

**3.**

_____ I am unable to speak clearly due to deep-seated grief or shock.
_____ I have issues of letting go or forgiving myself or others for past traumas.
_____ I am carrying grief which belongs to a family member or ancestors.
_____ I carry this grief because it still serves me.

**4.**

_____ I listen to my own inner voice when I make decisions in my life.
_____ I hang on to the status quo so as not to make mistakes.
_____ I learned this from my family.
_____ I am following and listening to my spirit guides and aware of my true destiny or path in life.
_____ I am conforming to my family's expectations of me, not my own.

**5.**

_____ I am carrying deep grief for my family or ancestors.
_____ I find it difficult to forgive myself and others.
_____ Some members of my family have severe psychospiritual imbalances—sleep all the time, have a poor or foggy memory, are incessantly crying or melancholy, or talk to themselves.

_____ I am working out my own karma.
_____ I am carrying karma for my ancestors.
_____ I harbor anger toward myself and others due to deep emotional hurts and injustices.
_____ This anger is not mine.

**6.**
_____ I am following my own creative path in life.
_____ I am doing what someone else expects of me.
_____ I am resentful and angry at my family for this.
_____ I am following my mother's or father's career path, either because they could not, or they failed to achieve the success for which they yearned.

**7.**
_____ I have karmic patterns lodged in my throat.
_____ I hang on to rigid thinking and control due to my fear of success and abundance, and reject the presence of love and joy in my life.
_____ I am carrying this fear and control for my family or ancestors.

**8.**
_____ I have been abused and betrayed in my life.
_____ I am carrying this cellular memory for my family or ancestors who experienced this violation themselves.
_____ I have fears regarding intimacy and commitment.
_____ This fear is not mine.
_____ I close off my heart to myself and others out of fear and a need for protection.
_____ I have learned how to protect myself in this way from my family.

**9.**
_____ I have experienced post-traumatic stress, such as whiplash from car accidents, etc.
_____ I blame others for my problems.
_____ These problems are my own.
_____ I am carrying these patterns for my family.

**10.**
_____ I have a blocked throat chakra and sometimes clogged ears or ringing in the ears.
_____ I have ambitions that are not in alignment with my true self.
_____ I am following this path to please my family.
_____ I want money and power.
_____ I have ego desires that are not in alignment with my true path and divine energy.

## Consent and Confidentiality Agreement

_____All sessions at **Sonic Facelift Scottsdale, LLC** are designed to promote balance, harmony, and overall well-being. Sessions may incorporate various holistic modalities, including sound therapy, vibrational healing, energy balancing, intuitive guidance, Reiki, and Acutonics®. These services are intended to support the body's natural healing abilities and to complement—not replace—conventional medical or psychological care.

_____Tami Holly **does not diagnose** conditions, prescribe substances, perform medical treatments, or interfere with the care of licensed medical or mental health professionals. Clients are responsible for their own health decisions and are encouraged to seek appropriate professional medical or psychological care for any conditions or concerns.

## Consent to Photograph and Use in Advertising

_____I hereby grant **Sonic Facelift Scottsdale, LLC**, its representatives, employees, and agents, the irrevocable right and permission to photograph, video record, and/or otherwise capture my likeness, image, voice, and/or appearance (collectively, "Images") during my services or participation with **Sonic Facelift Scottsdale, LLC**.

_____I understand and agree that these Images may be used for lawful business purposes, including but not limited to advertising and marketing materials, websites and social media platforms, print materials (brochures, flyers, business cards), educational or promotional content.

_____I acknowledge that I will not receive compensation for the use of these Images, I waive any right to inspect or approve the finished Images or their use, all Images are the sole property of **Sonic Facelift Scottsdale, LLC**.

_____I release and hold harmless **Sonic Facelift Scottsdale, LLC** from any claims, demands, or liability arising out of the use of the Images, including but not limited to claims for invasion of privacy, defamation, or misrepresentation.

_____I consent to use on social media

_____I consent to use on website

_____I consent to before-and-after photos

_____I prefer my face not be shown

_____This consent is given voluntarily and may not be revoked once the Images are published or distributed.

_____I confirm that I am at least 18 years of age and that I have read, understand, and agree to this consent.

## Reiki

_____I understand that Reiki is a gentle, hands-on energy technique used to promote relaxation and stress reduction. Reiki practitioners do not diagnose medical conditions, prescribe or perform medical treatments, or interfere with care provided by licensed healthcare professionals.

_____I understand that Reiki is not a substitute for medical or psychological care and that I should consult a licensed physician or healthcare provider for any physical or mental health concerns.

_____I acknowledge that the body has an innate ability to heal itself and that achieving a state of deep relaxation can support this process. I understand that long-term imbalances may require multiple sessions to facilitate healing and alignment.

## Acutonics®

_____I understand that **Acutonics®** is a non-invasive therapeutic methodology based on principles of Traditional Chinese Medicine that uses sound vibration to promote balance and wellbeing. In an Acutonics session, specific vibratory frequencies are created using precision-calibrated tuning forks, hand chimes, and planetary gongs.

_____I understand that these frequencies are scientifically derived from the orbital properties of celestial bodies and are applied to acupuncture points, chakras, and areas of discomfort to encourage energetic harmony. The Acutonics Institute of Integrative Medicine developed this modality, emphasizing the partnership between practitioner and client and the integration of conventional and alternative approaches to health.

_____ I understand that Acutonics does not diagnose, cure, or treat specific medical conditions. It is a complementary, therapeutic, and integrative approach designed to promote overall wellness and balance. A treatment plan will be discussed and reviewed prior to my session.

_____I acknowledge that the services provided by Sonic Facelift Scottsdale are complementary and intended to support overall wellbeing. I understand that these services are not a replacement for medical or psychological treatment.

## LED Light Therapy

_____I understand that LED light therapy is a non-invasive, low-risk cosmetic wellness service and is not a medical treatment. I acknowledge that results are not guaranteed and may vary. I certify that I have disclosed all relevant health conditions, medications, sensitivities, and pregnancy status to my provider.

_____I consent to receive LED light therapy and assume all risks associated with the service, including rare or unforeseen reactions. I hereby release and hold harmless Sonic Facelift Scottsdale, its owners, employees, contractors, and affiliates from any and all claims, liabilities, damages, or expenses arising from or related to my LED light therapy sessions, except where prohibited by law.

## BioMat®

_____I understand that Biomat therapy is a non-invasive, low-risk wellness service that involves relaxing on a heated therapeutic mat using far-infrared technology (and other features specific to the device) and is not a medical treatment. I acknowledge that results are not guaranteed and may vary. I certify that I have disclosed all relevant health conditions, medications, implants/devices, sensitivities, and pregnancy status to my provider.

_____I voluntarily consent to receive Biomat therapy and assume all risks associated with the service, including rare or unforeseen reactions.

_____I assume all associated risks and release and hold harmless Sonic Facelift Scottsdale and its representatives from any claims arising from my Biomat therapy sessions, except where prohibited by law.

## Sonic Facelift™

_____I understand that the Sonic Facelift™ is a non-invasive, low-risk cosmetic/wellness service that uses vibration-based technology on the face and neck, and is not a medical treatment.

_____I acknowledge that results are not guaranteed and may vary. I certify that I have disclosed all relevant health conditions, medications, implants/devices, sensitivities, and pregnancy status to my provider.

_____I understand that my Sonic Facelift session may include the topical application of carrier oils, essential oils and/or manual facial techniques including LED gua sha.

_____I acknowledge that essential oils and topical products may cause sensitivity, skin irritation, allergic reaction, or other unexpected responses, especially with underlying allergies or sensitivities.

_____I confirm that I have disclosed any known allergies, sensitivities, skin conditions, or contraindications (including but not limited to pregnancy/breastfeeding status, asthma,

fragrance sensitivity, eczema, rosacea, active acne, cold sores/herpes simplex, recent peels/resurfacing, injectables, bruising tendency, blood-thinning medications, or facial inflammation).

_____I understand that gua sha involves light-to-moderate pressure and may result in temporary redness, tenderness, mild swelling, or bruising in some individuals. I consent to the use of gua sha as part of my service and agree to notify my provider immediately if I experience discomfort or wish to stop.

_____I assume all associated risks and release and hold harmless TamiHolly.com and its representatives from any claims arising from the use of essential oils, topical products, or gua sha during my session, except where prohibited by law.

By signing below, I indicate that I have read and fully understand the information provided above. I voluntarily consent to receive services from Sonic Facelift Scottsdale and release the practitioner(s) from any liability related to my participation.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

## Emergency Contact Information

Name: _____

Relationship: _____

Phone: _____ Alternate Phone: _____

## Preparing for Your Session

Your session begins well before you arrive. Take time to unwind, slow your breath, and set an intention for what you would like to release or invite into your life. To prepare your system for the deepest benefit:

- Complete your client information packet in advance.
- Allow at least 30 minutes before the session to relax and quiet your mind.
- Write down any themes, emotions, or questions you would like to explore.
- Avoid caffeine, alcohol, sweets, and smoking the morning of your appointment, and drink plenty of water.
- Eat a light, nourishing meal a few hours before the session; avoid heavy or fried foods.
- Wear comfortable clothing.
- An Epsom salt bath before or after your session can help clear residual energy and support relaxation.
- Hydrate throughout the day with at least six to eight glasses of water.

## In-Person Sessions

Your in-person experience takes place in a private healing space designed to feel calm, restorative, and grounded. Before each appointment, the space is cleansed and prepared with care. I begin by activating the Seraphim Blueprint healing frequencies and performing an aura and chakra cleanse to ready your energy field for the session.

When you arrive, we'll briefly discuss your goals and determine the approach that best supports you. While Reiki is traditionally practiced with light touch, it can be fully hands-off at your request. Each session may draw upon a range of modalities, including Holy Fire® III Reiki, Karuna Reiki®, Seraphim Blueprint frequencies, Acutonics® tuning forks, crystal placement, sound bowls, and aromatherapy.

The session itself is typically quiet, accompanied by gentle music. You may fall asleep, feel warmth or tingling sensations, or notice waves of deep calm. These are natural responses to energetic alignment. You should never feel discomfort—please communicate if you do.

## Distance Sessions

Distance sessions offer the same level of energetic focus and precision as in-person work. We will agree on a specific time for your session; choose a space where you can lie down undisturbed. You may wish to light candles, play soft music, or simply rest in stillness.

These sessions involve Reiki energy transmission and intuitive frequency alignment. BioMat® infrared therapy is available in-person only. Many clients report sensations of warmth, spaciousness, or deep rest, as well as a renewed sense of clarity following distance work.

## After Your Session

You may feel very relaxed or lightly disoriented, so give yourself time to rest and integrate. Drink water generously and nourish your body with clean, plant-based foods (if possible). A small piece of dark chocolate, root vegetables, red wine, or "Earthing" can help ground your energy.

An Epsom salt bath can further support release and relaxation. You may continue to feel subtle effects for several days as your body and energy field recalibrate. Some people experience emotional release or mild detox symptoms such as fatigue, vivid dreams, or temporary sensitivity. These are normal indicators of energetic realignment and typically ease within 24–48 hours.

Hydration, rest, and gentle movement are supportive. Journaling reflections or insights can also deepen the process. With continued sessions, many clients experience progressively deeper clarity, emotional balance, and a sense of vitality.