Angel Wings & Amethyst Healing House

Vibrational Bowl Sound Therapy Intake Waiver Form

First Name: _____ Last Name: _____Today's Date: _____

DOB: _____ Age: _____ Gender: Female____ Male ____ Other____ Marital Status: Single / Married / Divorced /

Separated / Widowed / Cohabitation / Other _____ Occupation:_____ Retired:_____

Address: _____City: _____State: _____ Zip Code: _____

Cell Phone: ( )_____Home Phone: ( )_____ Email: _____

Emergency Contact Name: _____Emergency Contact Phone: ( )_____

Have you received VBST before? Yes_____ No_____ Have you experienced other forms of vibrational or sound therapy before?

Yes_____ No_____ If yes, in what form? Please explain _____

Are you sensitive to touch? No_____ Yes_____ If Yes, please explain: _____

Are you sensitive to perfumes or fragrances? No____ Yes____ Are you sensitive to burning incense / smudges? No_____ Yes____

Do you have any allergies? No_____ Yes_____ If Yes, please list: _____

Are you sensitive to sounds or vibrations? No_____ Yes _____ If Yes, please explain: _____ Do you have

any health conditions that could arise during the session? No_____ Yes_____ If Yes, please indicate:_____

_____ In the event of an emergency, do you carry medication with you? Yes_____ No _____

If Yes, Type & Location? _____ Any difficultly laying on your back or stomach?

No____ Yes____ If Yes, please indicate: Back____ Stomach____ Both____ Reason? _____

The following list is imperative to answer completely, truthfully and in detail: (please note contraindications do not make you ineligible for treatment, however, it may be necessary to make modifications for your personalized session)

Are you Pregnant? Yes_____ No_____ If No, any possibility of Pregnancy? Yes_____ No_____

Do you have a Pacemaker or Internal Defibrillator? Yes_____ No_____ Body Piercings? No_____ Yes _____ Location? _____

Do you have any Organ Transplants? Yes_____ No_____ If Yes, please indicate which Organ(s): _____

Do you have an Insulin Pump? Yes_____ No_____ Do you have a Pain Pump? Yes_____ No_____

Have you been diagnosed with AFib (Atrial Fibrillation)? Yes _____ No _____ If Yes, please explain: _____

Do you have Shunts or Stents? Yes_____ No_____ If Yes, location? _____

Do you have any Joint Replacements? Yes_____ No_____ If Yes, Location: _____ How Long? _____

Have you had any Surgical Bone Repairs (ORIF)? Yes _____ NO _____ If Yes, Location? _____

Are you currently under the care of any health care provider? Yes_____ No_____ If Yes, please circle all that apply: Primary

MD/PA/NP/DO, Chiropractor, Mental Health MD/DO/PSY.D/MSW/LCSW/LMFT, Physical Therapist, Massage Therapist, Specialty

MD, Please Specify:_____ Other:_____

Did you consult with a healthcare practitioner about VBST? Yes _____ No_____ If Yes, do you have clearance? Yes ____ No ____

Current medical conditions? _____

Medical History: (Please circle all that apply)

Arthritis
Abdominal Pain
Asthma or Allergies
Autoimmune Disease
Back Pain or Sciatica
Blood Clots
Blood Disorders
Brain Fog
Broken Bones
Cancer
Cardiac Conditions
Carpal Tunnel Syndrome
Chronic Digestive Disorders
Chronic Heartburn or Indigestion
Chronic Lung Conditions
Chronic or Acute Pain
Constipation or Diarrhea
Depression or Anxiety
Diabetes
Dizziness or Light Headed
Fatigue or Weakness
Glaucoma
Gynecological Disorders
Headaches or Migraines
High Blood Pressure
Insomnia or Sleep Disorders
Joint Pain or TMJ
Kidney Issues
Low Blood Pressure
Low Blood Sugar (Hypoglycemia)
Memory Issues
Menopause
Muscle Spasms or Cramps
Neck or Shoulder Tension
Nightmares or Night Terrors
Night Sweats
Numbness or Tingling
Organ Failure
Panic Attacks or OCD
Poor Circulation
Rashes or Skin Conditions
Respiratory Issues
Seizure Disorder
Sexual Disfunction
Shortness of Breath
Sinus Problems or Esophagus Issues
Stress Related Conditions
Syncope (Passing out)
Thyroid Disorders
Tumors or Cysts
Visual Problems (blurred/double)

Other medical conditions not listed above: _____

Have you experienced any accidents, surgeries or hospitalizations in the last 2 years? No____ Yes____ If Yes, please explain in detail: _____

Which health condition or symptom are you most concerned with? _____

In your own words describe what is the main source of stress in your life? _____

_____

Emotional stress scale: *Please circle average Level 1=no stress 5=moderate 10=Extremely* 1 2 3 4 5 6 7 8 9 10

What steps have you taken to reduce stress in your life? _____

Do you currently use stress reducing techniques? Yes_____ No_____ If Yes, please describe: _____

Are you a caregiver for dependent's? Yes_____ No _____ If Yes, how many children? _____ Adults? _____ With disabilities? ____

MY GOALS FOR SOUND THERAPY: *Please mark all that apply*

Relaxation ____ Pain Relief ____ Stress Reduction ____ Balancing ____ Mind Clarity ____ Self-Care ____ Clearing ____

What are your intentions for future therapy sessions? ____ This is it (at least I tried it) ____ Yearly (that's all I allow myself)

____ Twice a Year (could be less) ____ Monthly (I need this) ____Biweekly (like my pay) ____ Weekly (my health is a priority)

Everything I have written and answered on this form is true to the best of my knowledge. If my condition changes, I agree to disclose to my practitioner and update my files.

I understand that VBST is a simple, gentle, sound massage technique that is used for stress reduction and relaxation. I acknowledge that treatments administered are only for the sole purpose of helping me relax and relieve stress. I understand that I will experience a series of bowls positioned on and/or around my body. I understand that VBST practitioners do not diagnose conditions nor do they prescribe or perform medical treatment, prescribe substances, nor interfere with the treatment of a licensed medical professional. I understand that VBST does not take the place of medical care. It is recommended that I see a licensed physician or licensed health care professional for any physical or psychological ailment I may have. I understand that VBST can complement any medical or psychological care I may be receiving. I also understand that the body has the ability to heal itself and to do so, complete relaxation is often beneficial. I acknowledge that I have complete control over my body, mind, and spirit, I can create or manifest dis-ease within. I acknowledge that long term imbalances in the body sometimes require multiple sessions in order to facilitate the level of relaxation needed by the body to heal itself. I also acknowledge that it is in my best interest to give myself permission to relax and allow the process to flow freely. I also understand that I am safe and at any time I feel uncomfortable I am free to open my eyes and ask the practitioner to stop.

Having read, completed and understood the foregoing, I request to receive VBST treatments. I understand that my practitioner is providing a VBST treatment for me at my request and is not responsible for the outcome of the session(s). I agree to hold Terri Buccilli or Yoga in Manor Park *harmless* for any intended or unintended result. I have read and understand the above and I attest that the above information is true and correct.

VBST Recipient - Print Name: _____

Recipient / Parent if under 18 - Signature: _____ Date: _____