WAVES OF GRACE
SOUND THERAPY

Name: _____

Phone: _____

Email: _____

Emergency Contact: _____

Phone: _____

Please indicate your intention for this session: _____

_____

Please check any that apply:

Main objective for the therapy
[ ] Relaxation/Meditation
[ ] Physical
[ ] Emotional

Health History
[ ] Heart condition or pacemaker
[ ] Epilepsy or seizures
[ ] Pregnancy
[ ] Recent surgery
[ ] Metal implants
[ ] Hearing sensitivity or tinnitus
[ ] Mental health conditions (please specify): _____

[ ] Other (please specify): _____

Session Type
[ ] I would like a Scriptured Session
[ ] I would like a Secular Session

Aromatherapy Scent
[ ] Lemongrass
[ ] Lavendar

I confirm that the information provided is accurate and complete to the best of my knowledge.

_____ _____ _____ _____

Client Signature Date Practitioner Signature Date