

## **Heal to Heal General Intake Form and Waiver Personal Information:**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email: \_\_\_\_\_ Phone: \_\_\_\_\_  
Occupation/s: \_\_\_\_\_ Physical  
Activities: \_\_\_\_\_ Emergency  
Contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Sound and

### **Medical Information:**

Have you had a professional Sound Therapy Session before? Y/N Level of stress: (5 - Highest, 1 - Lowest)  
\_\_\_\_\_

What is the main source of stress in your life? \_\_\_\_\_

Do you have sensitivity to sound or vibration? Y/N \_\_\_\_\_

Do you have difficulty lying on your front or back? Y/N Please explain: \_\_\_\_\_  
\_\_\_\_\_

Any accidents or surgeries in the last 2 years? Y / N \_\_\_\_\_

Any metal or other implants or pacemakers etc.? Y / N \_\_\_\_\_

Are you Pregnant? \_\_\_\_\_ If YES, how far along are you? \_\_\_\_\_ weeks

### **Please check all that apply:**

\_\_\_\_ Lymphatic conditions: swollen gland, nasal congestion or Lymphedema. \_\_\_\_ Joint health: stiffness, arthritis, sacroiliac discomfort, TMJ or other. \_\_\_\_ Bone conditions: osteoporosis, fracture or other.  
\_\_\_\_ Headaches or migraines. \_\_\_\_ Recent injury or accident: whiplash, sprain, bruise or other.  
\_\_\_\_ Numbness or tingling. \_\_\_\_ Tendonitis or bursitis. \_\_\_\_ Diabetes. \_\_\_\_ Circulatory conditions: high blood pressure, varicose veins or blood clots.

### **Please review and initial the following statements:**

If I experience pain or discomfort during the session, I will immediately inform my therapist so that any pressure or techniques applied can be adjusted to my level of comfort. \_\_\_\_

I will not hold my therapist responsible for any pain or discomfort I experience during or after the session. \_\_\_\_

I understand that the services offered today are not a substitute for medical care. I also affirm that I have notified my therapist of all known medical conditions and injuries. I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist due to experiencing the sound session. \_\_\_\_

Sound Therapy is contraindicated for certain medical conditions. I affirm that I have discussed all my know medical conditions with the Therapist and my Physician and I am choosing to proceed with the session. I have completed the information on this consent honestly. I understand that I should see a physician or qualified medical specialist for any mental or physical ailment of which I am aware. I agree to keep the Therapist updated as to any changes in my medical/physical conditions that might affect my ability to safely receive my Sound Session. \_\_\_\_\_

By signing this release, I hereby waive and release Heal to Heal LLC and my therapist Renee Boos and her heirs from any and all liability, past, present and future relating to Heal to Heal LLC. \_\_\_\_\_

I understand that should I cancel or reschedule an appointment less than 24 hours before the scheduled time or don't show up to the appointment, I am subject to a fee equal to the full cost of the missed appointment. If the appointment was booked under gift certificate, or package, it will be voided or redeemed in lieu of the fee. I also, understand all sales are final, no refunds. \_\_\_\_\_

\*In general, sound therapy is done while fully clothed. This is your session and you should be as comfortable as possible, please do wear comfortable clothes.

\*Sound Therapy is a therapeutic, professional service. Inappropriate or sexual conduct of any kind, initiated by any party will not be tolerated. If uncomfortable for any reason, the client or therapist may ask to end the session, and the session will end.

I have received this policy statement and have read and agreed to all of the policies therein:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_