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|---|---|---|
| Name:   | Date:   | Occupation:                                     |
| Address:  | Phone:  | Date of Birth:                                  |
| City:   | State:  | Zip Code:                                       |
| Emergency Contact Name:   | Phone:  |   |
| How did you hear about us:  | Referral Name:                                  |   |
| <b>GENERAL HEALTH</b>   |   |   |
| 1. Rate your level of stress: (5 = highest, 1= lowest)    5   4   3   2   1   |   |   |
| 2. What is the main source of stress in your life?  |   |   |
| 3. Do you have any sensitivity to sound or vibration? <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |
| 4. Do you have any difficulty lying on your front or back? <input type="checkbox"/> Yes <input type="checkbox"/> No    Please explain which side and the issue? |   |   |
| 5. Please list any accidents or surgeries in the last 2 years   |   |   |
| 6. Do you have any metal implants, a pacemaker or body piercings?   |   |   |
| 7. List the medications you are currently taking:   |   |   |
| <b>VIBRATIONAL SOUND MASSAGE</b>  |   | <b>GOAL FOR YOUR VSM SESSION</b>                |
| Have you ever had a singing bowl massage before? If so, when?   |   | <input type="checkbox"/> Relaxation             |
| Do you have any allergies?  |   | <input type="checkbox"/> Pain Relief            |
| Is there any area of your body you do not want the bowls to be placed?  |   | <input type="checkbox"/> Stress reduction       |
| <b>HEALTH HISTORY</b>   |   |   |
| <input type="checkbox"/> Heart Condition  | <input type="checkbox"/> Psychiatric Disorder   | <input type="checkbox"/> Herpes/Shingles        |
| <input type="checkbox"/> Numbness/Tingling  | <input type="checkbox"/> Sinus Problems         | <input type="checkbox"/> Allergies              |
| <input type="checkbox"/> Rashes   | <input type="checkbox"/> Jaw Pain/TMJ           | <input type="checkbox"/> Blood Clots            |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Gas/Bloating           | <input type="checkbox"/> Headaches              |
| <input type="checkbox"/> Broken/Fractured Bones   | <input type="checkbox"/> Pregnancy ( ___ weeks) | <input type="checkbox"/> Fatigue/Sleep Disorder |
| <input type="checkbox"/> Other (explain):   | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Low Blood Pressure     |
| <input type="checkbox"/> Chronic Pain   | <input type="checkbox"/> Varicose Veins         | <input type="checkbox"/> Sprains/Strains        |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Spasms/Cramps          | <input type="checkbox"/> Cancer                 |
| 1. Are you currently under the care of a doctor or physician?   |   |   |
| 2. Have you informed your primary care provider that you are receiving VSM treatments?  |   |   |
| 3. Are you currently using any additional techniques to manage stress?  |   |   |

It is my choice to receive Vibrational Sound Massage and I understand that the practitioner will be using gentle sound and vibration during the sessions on/around me. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update my practitioner of any changes to my health status. I understand that practitioners certified by the Vibrational Sound Association do not diagnose illness, disease, or physical or mental disorders, nor do they prescribe medical treatments or pharmaceuticals. I acknowledge that these sessions are not a substitute for medical examination or diagnosis, and that is recommended I see a primary health care provider for those services. I understand that I alone am responsible for informing my primary health care provider I am receiving these sessions and inquiring as to whether or not they may adversely affect my current health condition.

Signature

Date

Privacy Policy: No information about any client will be discussed or shared with any third party without written consent of the client or parent/guardian if the client is under 18.