Nancy's Vibrational Healing Sounds
Intake form

Name			Occupation:
Address:			Date of Birth:
City:	State:	Zip:	Email:
Emergency Contact:			Cell/Phone:
How did you learn about us:			

General Health

Relaxation Methods you practice:
Main Sources of Stress in your life:
Any sensitivity to sound or vibration?
Any difficulty lying on your front or back? If yes please describe:
List any accidents or surgery in the last 2 years:
Any metal implants, pacemakers or body piercing: If yes please describe:
List medications currently taking:
Name and phone number of your Physician:

	Goals for Today
Have you ever undergone VST or Reiki before? If yes when?	□ Relaxation
Known allergies:	□ Pain Relief
Body areas on which you do not want bowls placed?	□ Stress Relief

Health History-Circle all that apply

Heart Condition	Psychiatric Disorder	Herpes/Shingles	High Blood Pressure	Low Blood Pressure
Numbness/Tingling	Sinus Problems	Allergies	Chronic Pain	Varicose Veins
Rashes	Jaw Pain (TMJ)	Blood Clots	Constipation	Sprains/strains
Diabetes	Gas/Bloating	Headaches	Arthritis	Spasm/Cramps
Broken/Fractured Bones	Fatigue/Sleep Disorders	Depression/Anxiety	Cancer	Pregnancy___weeks

Other (explain):

1.Rate Stress Level before Session (on a scale from 1 to 10 with 1 being low 10 being highest)

2.Rate Pain Level before Session (on a scale from 1 to 10 with 1 being low 10 being highest)

3.Rate Anxiety Level before Session (on a scale from 1 to 10 with 1 being low 10 being highest)

I have chosen to received Vibrational Sound Therapy/Reiki. I understand that Nancy Figueroa-Galarza will be using gentle sound and vibration techniques, and hands on energy techniques to promote relaxation and stress reduction. I have completed this form to the best of my knowledge. I have stated all medical conditions of which I am aware. I will update Mrs. Figueroa-Galarza with any changes in my health. I understand that she does not diagnose illness or disease. She does not perform medical treatments or prescribe pharmaceuticals. She will not interfere with treatments by any medical professional. I acknowledge that these sessions are not a substitute for medical or psychological examination or diagnosis, and I shall see a licensed health care provider for those services. I understand that I alone am responsible for informing my health care provider that I' m receiving these sessions.

Privacy Policy: No information about me (or any minor child) will be shared with any third party without my written consent.

Signature Date:

Reiki Healing Association