Nyomi Sounds

Please complete and return prior to your sound therapy sessions to ensure we can best support your needs

Session date:
Name / Surname
Email
Phone number

Are you over 16 years of age? ☐ YES ☐ NO

Name of Parent/Guardian (if applicable)____________________________________

Have you recently had any major or minor surgery? ☐ YES ☐ NO

If yes please give details:____

Are you taking any prescribed medications? ☐ YES ☐ NO

If yes please list name and use:____

____

Are you taking any alternative/unprescribed medication or supplements ☐ YES ☐ NO

please specify______________________________

Are you currently pregnant? ☐ YES ☐ NO

If yes, how far along? ____________ any high risk factors?____________________

Do you suffer from chronic or long term pain? ☐ YES ☐ NO

If yes, please explain____

What makes it better?____

What makes it worse? ____

Do you have any mental health conditions? ☐ YES ☐ NO

If yes, please provide details:____

Do you have any allergies or sensitivities? ☐ YES ☐ NO

Please explain ____

Please tick any of the following which apply:

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- [ ] **Cancer**
- [ ] **Headaches/Migraines**
- [ ] **Arthritis**
- [ ] **Diabetes**
- [ ] **Joint Replacement(s)**
- [ ] **High/Low Blood Pressure**
- [ ] **Fibromyalgia**
- [ ] **Stroke**
- [ ] **Heart Attack/Pace maker**
- [ ] **Sound induced Epilepsy**
- [ ] **Hearing aids**
- [ ] **Blood Clots**
- [ ] **Metal Implants**
- [ ] **Asthma**
- [ ] **Numbness**
- [ ] **Sprains or strains**

Anything not mentioned which you feel is relevant ________________________________

Have you been diagnosed with any unmedicated conditions? ☐ **YES** ☐ **NO**

Please provide details: ____

Have you had sound therapy before?

☐ Follow up session ☐ External session

What are your goals for this session? ____

____

Are you currently having any therapies? ☐ **YES** ☐ **NO**

Which one/s? ____

Which approach suits you best?

☐ Physical / Pain relief therapy ☐ Spiritual Auric therapy

Are you able to lay on a yoga mat at floor level?

Are you able to get on and off a massage couch unaided?

Where did you hear about us?

Would you like to be added to our mailing list via your email? ☐ YES ☐ NO

By signing below, you agree to the following.

- I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time
- The therapist can discontinue or defer treatment where justifieable and appropriate.
- Safe storage of your personal information in line with the 2018 data protection act.
- You are aware and undersand the purpose of this form.

Client Signature ______________________________ **Date**______________________

Therapist Signature ____________________________ **Date**______________________

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