DAVID KEY MUSIC

Sound Therapy Client Intake Form

Date ___________________

Name ____

Street Address ____

City ___________________________ Zip __________________

E-Mail __________________________________ Cell Phone __________________________

Please list any existing injuries ____

Please list any surgeries ____

What do you hope to gain from sound therapy today?

____

Check any that apply:

☐ hearing aid
☐ hearing loss
☐ sound sensitivity
☐ cochlear implant
☐ pain in one or both ears
☐ pacemaker
☐ seizure disorders
☐ other areas of concern: _____________________

Please sign below after reading this information.

I understand that a Sound Therapist is not a doctor and cannot prescribe, diagnose, or treat for any condition. The treatments provided are for the purpose of relaxation and should not be construed as a substitute for medical exams, diagnosis, or treatment by a physician or other medical professional. Receiving sound therapy does not require that I stop any medications prescribed by a physician, nor does it suggest that I should refuse care of a medical professional. I affirm that I have stated my medical conditions and answered all questions honestly, and that I have read and understand this disclaimer.

Signature____ Date _______________

17 INDIGO COURT, HAMPSTEAD, NORTH CAROLINA 28443