



NAME.....
ADDRESS.....
.....
.....

PHONE NO.....
EMAIL.....
DOB / /

GP DETAILS
NAME.....
ADDRESS.....
.....
PHONE NO.....

RELEVANT PAST MEDICAL HISTORY:
(include physical, emotional psychological)
.....
.....
.....

RELEVANT CURRENT MEDICAL HISTORY:
(include physical, emotional psychological)
ANYTHING ELSE I NEED TO KNOW? Y/N
(Pacemaker, epileptic, pregnant, osteoporosis?)
.....

HEARING PROBLEMS? Y/N
Any sounds you do not like? ie Drum, rattles, gongs etc:
.....
.....

MEDICATION.....
.....
.....

HEALTH Please score 0-10 (10 being the best health)
Physically / 10
Mentally / 10
Emotionally / 10
Spiritually / 10
Main Issue right now?
.....
.....
.....
.....

Signed:.....
Date.....

WHAT DO YOU WANT TO ACHIEVE FROM SOUND THERAPY?
.....
.....
.....

ACTIONS AGREED / PLAN FOR THE SESSION
DATE:
TIME.....
FORKS.....

HANDS ON/STEAMING.....

OTHER.....
.....
.....

OUTCOME OF SESSION:
.....
.....
.....
.....
.....
.....
.....
.....

Disclaimer – I agree to allow Linda Perry to work with me to form a plan of holistic healing, and agree to all modalities to be considered. I understand a series of sessions may be suggested. Holistic healing modalities include Sound Healing, Chakra Clearing and Re-balancing, Crystal healing. (discussed where going to used and or appropriate). A full assessment has been carried out and I have given honest and comprehensive answers. I have disclosed **all** relevant information regarding my health and well being, including physical, mental, emotional and spiritual. I will consult my Medical Practitioner should the need arise. I will not stop taking any medication unless my GP advises. I allow any information to be used in research or case studies and understand anonymity and confidentiality will be maintained.

Signed:.....
Date.....