



Rhythm of Expression, LLC

## Crystal Singing Bowl Sound Therapy

### CLIENT INTAKE FORM

We appreciate you taking the time to review this information, complete the enclosed form and supply us with the items requested below.

***Please fill out this New Client Assessment form prior to your appointment and send it back at least 5 days in advance to (email). If the form is received the day of our meeting, we may need to spend time reviewing it, which takes time away from your healing session.***

Your healing sessions will consist of a quick introduction before we start and a wrap-up afterwards.

### CANCELLATION POLICY

If you need to reschedule or cancel your appointment, please notify us at least 48 hours in advance to avoid a cancellation fee. Any sessions cancelled within 48 hours, will incur the full session fee.

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By placing an "x" in the box above and entering your name, you agree to the Cancellation Policy for this session and future sessions. This is required for any and all sessions booked.

### INFORMED CONSENT FORM

The United States of America currently has no licensing policy in regard to Sound or Energy Healing, and Rhythm of Expression, LLC and Melissa Steffy is not a licensed Medical Doctor or therapist. I do not deal with drugs, nor do I issue a diagnosis or suggest cures.

My purpose is simply to provide a safe space for my client to experience healing through natural processes. I consider the use of sound, energy, herbs, essential oils, crystals and any other natural healing modality as a way to encourage the body to get back to optimal functioning and everyone reacts to these methods individually. I make no claims for their medicinal actions, nor do I cite scientific evidence. Any information offered is done so on the basis of personal experience and traditional uses.

My clients agree to make their own choices as to what they do with the educational material they have been offered and are solely responsible for their own decisions and actions. It is always my recommendation to seek out the advice of a licensed health care professional whenever they feel it is necessary in regards to their own personal health, especially with serious conditions. Clients need to consult with their physician and get approval to attend healing sessions if they have metal in their bodies, suffered concussions, have a pacemaker, use an insulin pump, and the like. If in doubt, consult your physician before our time together.

Some issues such as suicidal thoughts or late-stage cancer are beyond the scope of my expertise and I would advise you to seek outside help.

I understand that:

- An assessment will be conducted to determine the general health of my energy system
- Any suggestion made by (your name) will be to assist my body's natural ability to achieve a balanced state, to the extent that my body or my highest knowing will allow
- The goal of my session will be identified as part of the initial process and that I will have input as well as give intent and permission for it.
- These sessions are not meant to replace treatment by established medical practices, and can complement them.
- There are no guarantees as to the results of treatment
- (your name) is not a licensed physician and will neither diagnose nor prescribe any condition nor does she make any specific claims regarding results from the sessions that I receive. Nothing in the work (your name) does is considered the practice of medicine.

I agree to:

- Raise any questions or concerns about anything I do not understand.
- Consider any suggestions that the practitioner may raise concerning referrals to other health care practitioners, homework, or my desired focus/introspection.
- Take full responsibility for my own health care.
- Give consent to (your name) to conduct a session to balance my energy system. I acknowledge that this could involve touch and I can request otherwise.

## **WHAT TO EXPECT**

In general, a typical session begins with a short assessment to discuss your concerns, thoughts or questions. During the session you can choose to sit or lay down. While we try to make you as comfortable as possible, if you have specific needs, please bring your own pillow or blanket, etc. We make every effort to assure that our clients feel safe and comfortable.

We may work on your body or above your body, so please let us know if there are any areas that you do not want work done. If you do not wish to be touched please let us know. Our work is intuitive so we feel the energy and work where the energy is stagnant, deficient, stuck or unbalanced. You may feel many different results such as heat or cold, shivers, nausea,

headache, relaxation, release, relief, ect. You may also feel nothing at all. Any reactions can happen immediately or even months later. No reaction is positive or negative, it purely is. It may mean something to you right away or it could be a mystery for a while. Both are normal. We find that energy medicine has a cumulative effect, so when you treat yourself to regular sessions, better health and well-being are natural outcomes. At the end, we will check in about anything that came up for you during the session.

I have read the above statements and I understand and agree with them. My purpose to seeking the advice of (your name) is done so for educational purposes only.

I understand that (your name) do not diagnose illness, disease, or mental disorder. Nor do they prescribe medical treatment or pharmaceuticals. It has been made clear that my session is not a substitute for medical examination or diagnosis and that it is recommended that I see a medical doctor for any physical or mental ailment.

I agree that (your name) cannot be held liable for any problems that might arise that I think could be attributed to the energy healing session. I have stated all of my known medical conditions to (your name) and if necessary I will keep her updated on my physical, mental, and emotional health. I acknowledge that (your name) practices for the purpose of providing mental/emotional/physical and spiritual support multiple techniques. I attest that I understand the nature of the session and freely elect to receive the techniques. I release (your name) from any and all claims of malpractice, non-disclosure, or lack of informed consent.

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By placing an "x" in the box above and entering your name, you agree to the Informed Consent.

## HEALTH PROFILE

Name:	Age:	
Phone #: (HOME)	(CELL)	
Preference: <input type="checkbox"/> Home <input type="checkbox"/> Cell		
Full mailing address:		
E-mail Address:	Referred by:	
Date of Appointment:	Day of Week:	Time:

What is your current health goal/what do you hope to get out of this session?

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### AREAS OF CONCERN:

In this section, list your main issues and rate them by severity **on a scale of 1-10, with 10 being the most severe.**

*Please note that we will address as many issues as possible, but it's often best to deal with fewer at a time. This is why booking multiple sessions is important.*

Issue	Severity

What do you believe is/are the cause(s) of these issues?

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What have you done thus far to help alleviate these issues?

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Are you currently under the care of a physician? If so, what for?

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What are your most pressing current physical and emotional health issues (acute and chronic)?

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Any past accidents? Operations?

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Do you have any specific spiritual practice?

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Anything else you think I should know?

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Allergies		
Do you have allergies?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, to what?
Medication or herb allergies?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, to what?
Food allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes, to what?
Sensitive Skin?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, to what?

Emotional Checklist
Put an X next to each statement that corresponds to the way you often feel.
<input type="checkbox"/> Anxiety and feeling overwhelmed or stressed, especially anxiety felt in the body, or physical anxiety
<input type="checkbox"/> Feeling worried or fearful
<input type="checkbox"/> Have intrusive thoughts, have an overactive brain, or have unwanted thoughts – especially thoughts about unpleasant memories, images or worries
<input type="checkbox"/> Panic attacks
<input type="checkbox"/> Unable to relax or loosen up
<input type="checkbox"/> Stiff or tense muscles
<input type="checkbox"/> Feeling stressed and burned-out
<input type="checkbox"/> Obsessive thoughts or behaviors
<input type="checkbox"/> Perfectionism or being overly controlling
<input type="checkbox"/> Irritability
<input type="checkbox"/> Winter blues or seasonal affective disorder
<input type="checkbox"/> Negativity or depression
<input type="checkbox"/> Excessive self-criticism
<input type="checkbox"/> Craving carbs, alcohol, or drugs for relaxation and calming
<input type="checkbox"/> Low self-esteem and poor self-confidence
<input type="checkbox"/> PMS or menopausal mood swings
<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Anger or rage, agitated easily or irritated
<input type="checkbox"/> Digestive issues
<input type="checkbox"/> Fibromyalgia, temporomandibular joint syndrome, or other pain syndromes
<input type="checkbox"/> Difficulty getting to sleep
<input type="checkbox"/> Insomnia or disturbed sleep
<input type="checkbox"/> Lack of energy
<input type="checkbox"/> Lack of focus
<input type="checkbox"/> Lack of drive and low motivation
<input type="checkbox"/> Attention deficit disorder
<input type="checkbox"/> Heightened sensitivity to emotional pain
<input type="checkbox"/> Heightened sensitivity to physical pain
<input type="checkbox"/> Crying or tearing up easily
<input type="checkbox"/> Eating to soothe your mood, or comfort eating