Gong Therapy Client Intake Form

1) How many times have you experienced listening or relaxing with the gong? **0 1-5 6-10 10+**
2) Have you had past trauma around loud noises? **YES NO**
3) Do you wear hearing aids: **YES NO**
4) Do you practice yoga? **YES NO** If yes, what types and how often?

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5) Please describe your reason for having a gong therapy session:

_____

6) What do you consider to be your greatest health issue or personal challenge?

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7) How would you describe your general mental or emotional state?

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8) Please indicate any physical symptoms or illnesses that you have experienced recently.

9) Do you have any other questions about the gong therapy session or anything else you would like to share about yourself?

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