Health form and consent to treat

Please take a moment to respond to a few health and wellness inquiries. We abide by the code of ethics to protect your privacy and safety, and all information provided will remain confidential.

NAME: _____Address:_____

PHONE:_____Occupation:_____

When did you receive your last treatment?_____How do you feel today?_____

What do you wish to achieve in your treatment today? _____

Please circle any conditions you are experiencing currently:

Cold or flu	Severe Pain	Headache	Pregnancy
Cuts/bruises/rashes	H/L blood pressure	Diabetes	Epilepsy
Bone or joint disorders	Circulatory problems	cardiovascular disorders	

Communicable diseases: HIV; STD's; Herpes; Shingles; Hepatitis

Known allergies: _____

Are you under a doctor's care for any of these conditions? _____

Are you currently taking medications for any of the conditions listed above? Y/N

Medication/supplement_____

Have you received any surgical procedures or tattoos within the last 6 months? Y/N

If yes, please elaborate: _____

Are there any areas that you would like your therapist to focus on? _____

Would you like your therapist to recommend other treatment options with you? Y/N

In order to receive a service, please read the following information, sign and date.

I have informed my therapist of any condition which could affect the health and wellness of myself or my therapist during this treatment. I do not hold Sedona Wellness or its entities liable for any adverse affects from services rendered and products or equipment used. Sedona wellness and Lorrie Lawrence are not responsible for damage, loss or theft of personal property or to my person.

I affirm that I have read the above information and that I am 18 years of age or older.

Signature_____Date_____E-mail_____