

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: _____

City/State _____ ZIP _____ PHONE: _____

Occupation: _____ DOB: _____ EMAIL (Legible) _____

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 practitioner to focus on? _____

Would you like your practitioner 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 practitioner of any condition which could affect the health and wellness of myself or my practitioner during this treatment. I do not hold Sedona Wellness, LLC, Sedona Wellness, LLC dba Pagosa Wellness or its entities liable for any adverse effects from services rendered and products or equipment used, at its location or at off-site events and retreats. Sedona wellness, LLC, Pagosa Wellness dba Sedona Wellness ,and Sedona Wellness Institute, LLC is not responsible for damage, loss or theft of personal property or to my person.

I assume full responsibility for payment of services rendered by Sedona Wellness, LLC, Pagosa Wellness dba Sedona Wellness, LLC and its affiliates. The balance of payments due is required at the time of service. (Intl) _____

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

Signature _____ Date _____