

S E R E N I T Y W E L L N E S S

Name:	Date:
Address:	Home Phone
City, Zip	Work Phone
Email:	Cell Phone
Occupation:	Birthdate
Emergency Contact Name:	Contact Number:
Referred By?	

A contraindication is any indication or symptom that makes it inadvisable to use a particular therapy. The following are contraindications for FIR infrared sauna. If any of these apply to you we are not able to treat you with infrared sauna at the present time. *If you have any of these contraindications you may still be eligible to receive infrared sauna once they have subsided or been eliminated or if you are under the order, guidance and supervision of a qualified physician working with Serenity Wellness.

Yes	No	Condition
		Pregnancy
		High Blood Pressure
		Silicone Implants
		Pneumonia
		Pacemakers
		Multiple Sclerosis*
		Metal Pins or rods
		Chronic Nosebleeds
		Hemophilia
		Hyperthroidism
		Menstruation (may increase blood flow)
		Epilepsy*
		Claustrophobia*
		Cochlear Implants
		Diabetes* (currently on medication)

• Do you buy organically grown fruits and vegetables? ____, dairy and meat? ____

• Circle all that apply to your diet:

Raw foods	Eggs/dairy	Vegan	Vegetarian
Whole foods	Meat	Standard American diet	

• Describe your **daily** liquid intake in ounces (e.g. 8 oz. of water):

Water (filtered?)	Soda	Herbal Tea	Alcohol
Juice	Coffee	Black Tea	Other

- Describe your **daily** intake of the following:

Flour products/Bread	Sugar	Artificial Sweeteners	Soy Products
Dairy Products	Meats	Fried Foods	Fast Food

- Describe any known reactions or allergies to foods:

- Describe any known nutritional deficiencies:

- Describe your exercise habits:

- Describe other types of bodywork you receive:

- Rate on a scale (1-10) the stress in your life and describe

- Please list current supplements you are taking:

- Fiber: _____
- Friendly Bacteria: _____
- Digestive Support (enzymes/hydrochloric acid) _____

- Other _____

Cleansing Goals:

- How do you feel about the state of your health? What/How would you like that to change?

- Do you have interest in a specific type of cleanse?

- Are you or your partner trying to conceive? _____

I, the undersigned, have read and understand the guidelines for safe use of the far infrared sauna. I agreed to follow the recommendations regarding time, temperature and frequency of the sauna. I agree to report any adverse reactions immediately. I understand that the therapist does not diagnose illness, disease, or any other physical or mental disorder and does not prescribe medical treatment or pharmaceuticals. It has been made clear to me that FIR infrared sauna is not a cure, substitute for medical examination or diagnosis and that it is recommended that I see a physician for any ailments that I might have.

Signed: _____

Date: _____