Serenity Therapeutics LLC
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**BIOREGULATION ADULT INTAKE**

**(18 year old and older)**

Today's Date _____

Name _____ Date of Birth_____ Age _____

Address _____

Street City State Zip

Home Phone _____ Cell Phone_____

E-mail _____

Permission to leave message by phone, email or text: Yes or No _____

Marital Status: _____ Married _____ Divorced _____ Separated _____ Widow

Occupation _____ Employer _____

Person to contact in case of emergency: _____
Phone _____

Relationship to you _____

Whom may we thank for referring you? _____

Reason for evaluation_____

Have you been previously treated with Bioregulation? _____ If yes, where/when/location?

_____

_____

Number of sessions? _____ Reason for stopping treatment _____

_____

What are your current concerns?

_____

_____

_____

_____

Current Medications:

| Medication | For Condition | Dose | How long been on |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Current Supplements:

| Supplement | For Condition | Dose | How long been on |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Any current medical problems or recent surgeries?

_____

Are you receiving treatment for any health concerns? ____Yes ____ No If yes, explain _____

_____

If yes, who do you see for these concerns? _____

Please list any past health problems _____

Please list any treatment received for past health problems _____

_____

_____

_____

**I do not have a pacemaker/defibrillator _____(WE CANNOT TREAT DUE TO PULSED ELECTROMAGNETIC FIELD (PEMF)).**

**The information given is correct to the best of my knowledge.**

**Signature: _____ Date: _____**

**Print Name: _____ Relationship to Client: _____**