

Dr. Mel's Wellness Spa Services

916 SE Cape Coral Parkway

Cape Coral, FL 33904

239-542-1422

New Client Information Sheet

Name: _____ Birth Date: _____

Address: _____

City State Zip
Phone #: _____ Work/Cell #: _____

Email Address: _____ Referred By: _____

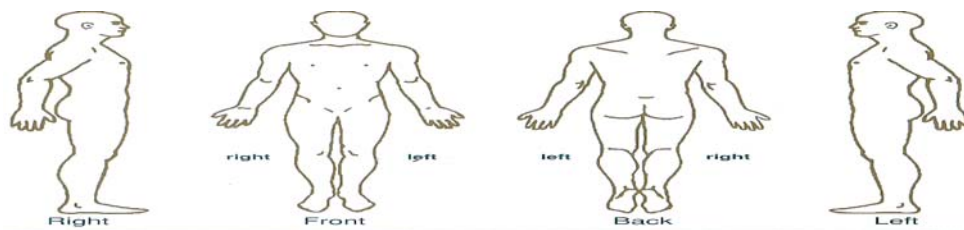
Emergency Contact Name and Number: _____

Reason for today's visit Emergency New Injury Old Injury Chronic

Are you in pain Yes No

Rate pain on following scale discomfort -1 2 3 4 5 6 7 8 9 10-intense pain

Please mark on the body the areas you are hurting:



Have you had any of the following medical conditions? Please circle Y or N

Y N	Shingles	Y N	Hepatitis	Y N	High/Low blood pressure
Y N	Severe/frequent headaches	Y N	Cancer	Y N	Artificial bones/joints/implants
Y N	Fainting/seizures/epilepsy	Y N	HIV/Aids/ARC	Y N	Arthritis

Females: Y N Pregnant How far _____

Please list anything you may be allergic to: _____

IRREVOCABLE AGREEMENT FOR PAYMENT

I clearly understand and agree that all services rendered by Dr. Mel's Wellness Spa, are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, that any fees for professional services rendered to me will be immediately due and payable.

I understand that as I am accepted as a patient of Dr. Mel's Wellness Spa Services, I authorize Dr. Mel and her staff to proceed with any spa services requested by me. Furthermore, any risks associated with the spa services provided, will be explained to me upon my request. We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I understand that Dr. Mel's Wellness Spa requires a 24 hour notice prior to cancelling or rescheduling an appointment. I am aware that if I do not call I will be charged a \$25 cancellation fee.

I have read and understand that my medical information is protected and completely confidential, consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature: _____ Date: _____