Your Name: Referred By: Today’s Date:

Address: City: State/Zip:

Preferred Contact Number: Email Address:

Height: Current Weight: Date of Birth: Age:

Marital Status: Are you Pregnant or Nursing: Yes No

How many bottles of water do you consume per day?

How many hours per week do you work?

How many hours per night do you sleep?

Occupation:

Are you currently under the care of a physician for any acute or chronic illness or disorder? Yes No

On a scale from 0-10 (10 being the worst) please rate your level of daily stress:

Have you ever had any conditions that affected your liver? If so, explain:

Have you ever had cancer? Yes No

Do you have an tattoos? If so, where?

Do you exercise? Yes No Type and Frequency:

What is your biggest “problem area”: Abdomen Face Arms Thighs Buttocks Cellulite

Have you ever had any cosmetic procedures or surgery? If so, explain:

What is your goal with red-light therapy? Please check all that apply:

\_\_\_ Weight Loss \_\_\_ Skin Tightening \_\_\_ Improved skin tone \_\_\_ Improved Cellulite

\_\_\_ Decrease in chronic pain \_\_\_ Improve wrinkles or stretch marks Other:

I clearly understand and agree that all services rendered are charged directly to me, and that I am personally responsible for payment. I understand that red-light therapy results are best seen in cumulative treatments and it is imperative to attend all my scheduled sessions, along with healthy nutrition and avoiding alcohol to achieve results.

Client Name (print):

Client Signature: Date:

Signature of Tech Reviewing Intake Form: Date: