

Practicing Whole Body Wellness

First Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

At your personal consultation, what are you interested in learning about?

___ UltraSlim Red Light Therapy ___ Fat Reduction ___ Skin Tightening ___ Pain Relief

___ Ultrasmooth Green Light For Cellulite Reduction

___ PNOE Metabolic Analysis

___ Emslim RF Muscle Stimulation

___ Far-Infrared Sauna

How did you hear about us?

___ Church Bulletin ___ Facebook/Instagram ___ Google Search ___ Walked/Drove By

___ TV Commercial ___ Radio: Which station? _____

Referred By _____

Health History Questionnaire

Circle Any Condition You Currently Have

Pregnant now or trying	Yes	No	Active Cancer within a year	Yes	No
Kidney Problems	Yes	No	Liver Problems	Yes	No
DR advised to avoid light	Yes	No	Autoimmune Disease	Yes	No
Lupus Erythematosus	Yes	No	Albinism	Yes	No

Check Any Photo-Sensitive Medications That You Take

<input type="checkbox"/> Gold Or Gold H	<input type="checkbox"/> Viacin	<input type="checkbox"/> Norfloxin
<input type="checkbox"/> Hostacycline	<input type="checkbox"/> Aratac	<input type="checkbox"/> LPF
<input type="checkbox"/> Chlorpromazine	<input type="checkbox"/> Vibramycin	<input type="checkbox"/> Ofloxacin
<input type="checkbox"/> Fulvicin P/G Or U/F	<input type="checkbox"/> Lymecycline	<input type="checkbox"/> Tetracycline Group
<input type="checkbox"/> Grifulvin V Or Griseofulvin	<input type="checkbox"/> Minocycline	<input type="checkbox"/> Mexate AQ
<input type="checkbox"/> Gris-Peg	<input type="checkbox"/> Tetrasal	<input type="checkbox"/> Bristacycline
<input type="checkbox"/> Achromycin/Acromysin V	<input type="checkbox"/> Cyclimiycin	<input type="checkbox"/> Ciprofloxacin
<input type="checkbox"/> Sumycin	<input type="checkbox"/> Amioderone	<input type="checkbox"/> Actisite
<input type="checkbox"/> Grisovin	<input type="checkbox"/> Minomycin Or Minotabs	<input type="checkbox"/> Thorazine
<input type="checkbox"/> Demecocycline	<input type="checkbox"/> Codarone X	<input type="checkbox"/> Tetrex
<input type="checkbox"/> Folex	<input type="checkbox"/> Terramycin	<input type="checkbox"/> Helidac
<input type="checkbox"/> Ledermycin	<input type="checkbox"/> Oxytetracine B-Oxylet	<input type="checkbox"/> Auranofin
<input type="checkbox"/> Cyclidox	<input type="checkbox"/> Terra-Cortril	<input type="checkbox"/> Azathioprine
<input type="checkbox"/> Doryx	<input type="checkbox"/> Cotet	<input type="checkbox"/> Chlorpromazine HC
<input type="checkbox"/> Methotrexate Sodium	<input type="checkbox"/> Oxypan	<input type="checkbox"/> Ridaura
<input type="checkbox"/> Doxycyl Or Doxytab	<input type="checkbox"/> Trexall	<input type="checkbox"/> Roaccutane
<input type="checkbox"/> Dumoxin	<input type="checkbox"/> Quinolone Derivatives	<input type="checkbox"/> Largactil
<input type="checkbox"/> PF	<input type="checkbox"/> Methotrexate	<input type="checkbox"/> Sonazine
<input type="checkbox"/> Noritet	<input type="checkbox"/> Nalidixic Acid	<input type="checkbox"/> Isotretinoin Accutane
<input type="checkbox"/> Other _____		

Signature _____

Date _____

Name _____

Date _____

Photo/Video Release

In consideration of uncompensated services, my receipt of which and the sufficiency of which are hereby acknowledged, I, the undersigned, hereby consent to allow the provider to make digital recordings of me (video, photographs, or other digital recordings) and grant all rights to any digital recordings of the possession of this provider or hereafter acquired, including all rights to exhibit and publish the works in print and electronic form, publicly or privately, and to market and sell copies and to use these in any and all types of media, now and hereafter known, for the purpose of marketing and promotions. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used except as provided herein.

*I further consent that my name and identity **MAY / MAY NOT** (circle one) be revealed therein or by descriptive text or commentary.*

I understand there will be no additional compensation or consideration for recording me or for any subsequent use. I represent that I am at least 18 years of age, have read and understand the foregoing, and am competent to execute this agreement.

Signature _____

DOB _____

Witness _____

Date _____