Infrared/Red Light Therapy

Contraindications and Consent Form

Name

DOB

Phone

Please answer the following questions about your health history. Your physician will discuss your health information in detail to decide what type of session best fits your unique health profile. Please be as honest as possible. Be assured this information is completely confidential.

		Yes	No
1.	Are you currently pregnant or breastfeeding?	◯	◯
2.	Are you under the influence of alcohol or drugs?	◯	◯
3.	Do you have any skin diseases, burns, open wounds, or reddening?	◯	◯
4.	Are you sensitive to heat?	◯	◯
5.	Do you currently feel lightheaded, drowsy, or feverish?	◯	◯
6.	Do you have any cardiovascular conditions, illnesses, or dieases?	◯	◯
7.	Do you have abnormal blood pressure or Hemophilia?	◯	◯
8.	Do you have any metal implants, such as pins, rods, artificial joints, or surgical implants?	◯	◯
9.	Do you suffer from MS, CNS Tumors, or Diabetic Neuopathy?	◯	◯
10.	Are you currently menstruating?	◯	◯
11.	Are you currently taking any diuretics, barbiturates, beta-blockers, or antihistamines?	◯	◯
12.	Do you have a pacemaker or defibrillator?	◯	◯

By signing below, I understand the above listed contraindications and consent to this health history questionnaire.

Signature

Date

Infrared/Red Light Therapy

Contraindications and Consent Form

By initialing all clauses below, I understand and consent to infrared/red light therapy treatment at Powell Chiropractic Health Center.

1. _____ I agree that I am over the age of 16, am NOT under the influence of alcohol or drugs, am NOT pregnant or nursing, and am capable of contracting in my name.
2. _____ I have been informed of the nature, risks, and possible complications and consequences of the infrared/red light therapy treatment. I understand the treatment may have known or unknown contraindications including but not limited to: certain medications including diuretics, barbiturates, anticholinergic, antihistamines and beta-blockers, pregnancy or breastfeeding, cardiovascular conditions/disorders/diseases, alcohol consumption in the previous 48 hours, chronic disorders or diseases associated with reduced ability to sweat, hemophilia, fever, joint injury, implants, and pacemakers.
3. _____ I understand the use of drugs, medication, or alcohol before or during the infrared/red light therapy session may lead to dizziness or unconsciousness.
4. _____ I request the use of infrared/red light therapy and accept the possible complications and consequences of using the treatment.
5. _____ I agree to cease my treatment session if I feel light-headed, dizzy, or heat exhausted.
6. _____ I have answered all questions on the client intake and health history form truthfully and to the best of my knowledge and abilities.
7. _____ I agree to hold Powell Chiropractic Health Center harmless of any claims, damages, or injuries incurred during or after the infrared /red light therapy treatment as a result of my failure to properly disclose my health history or as a result of an unknown disease or disorder I may have.

Signature

Date