CONFIDENTIAL HEALTH INFORMATION

Capitol Chiropractic and Family Wellness Center • Don Lathrop, D.C.
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Date:_____

Name_____

Date of birth _____

Gender_____

Address_____ City _____ State _____

Zip Code_____

Cell #_____ Home #_____

Email _____

May we send you text reminders for appointments? Yes □ No □

May we leave a voicemail? Yes □ No □

May we send you educational health care information via email? Yes □ No □

Referred to this office by _____

Your Symptom Survey Form

Your Name:

To the Best of Your Ability, Please Grade Each Category or Symptom on a Scale from 1 - 10, Where 10 Is Best

	CONDITION/CATEGORY	DATE:	DATE:	DATE:	DATE:	DATE:	DATE:	DATE:
1	Anxiousness							
2	Blood Pressure Issues							
3	Circulation/Swelling							
4	Constipation/Diarrhea							
5	Diabetes							
6	Dizziness							
7	Generally Cold or Hot							
8	Headaches							
9	Insomnia							
10	Kidney Health							
11	Require Drugs or Alcohol to Get Through the Day							
12	Ringing In The Ear							
13	Overall Alertness							
14	Overall Emotional Issues							
15	Overall Energy Level							
16	Overall Fitness							
17	Overall Gut/Digestive System							
18	Overall Happiness							
19	Overall Health							
20	Overall Heart/Circulation Issues							
21	Overall Immune System							
22	Overall Libido							
23	Overall Moodiness							
24	Overall Pain							
25	Overall Skin Condition							
26	Overall Sleep Issues							
27	Overall Stamina							
28	Overall Strength							
29	Overall Weight Issues							
30	Overall Female/Male Issues							
	TOTAL SCORE: (out of 300)							

DO NOT WRITE BELOW THIS LINE

Biological Age							
Visceral Fat %							
Overall Fat %							
Blood Pressure							
COMMENTS:							

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 Capitol 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 _Capitol Chiropractic 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

INFORMED CONSENT AND RELATIVE LIABILITY FORM

Consultation is required with Dr. Lathrop, D.C. to determine if you are a candidate for Red Light Therapy (RLT) and Whole-Body Vibration (WBV). RLT treatment is the application of red and near infrared wavelengths; WBV is a vibrating platform using specific frequencies and amplitudes. You will have the opportunity to ask questions or voice concerns you may have regarding these treatments. If it is determined, you are a candidate, you will be shown how to use the equipment. Optimizing your health goals will be discussed to create a plan for general wellness or weight loss.

1. 6 sessions is recommended to see or feel results. Typically, 3 sessions per week for 2 weeks. Future sessions to be determined for individual goals.
2. It is important to keep your appointments as this therapy is cumulative, and consistency is important.
3. Initially RLT is recommended every other day; this allows your body to process the effects. You may experience "detox" symptoms such as nausea, cold/flu, headache, sweating, muscle aches, fatigue, and low energy. This is normal when your body is getting rid of toxins.
4. It is very important to drink plenty of water, especially 45 minutes before each treatment and continue afterwards. This helps in flushing toxins out of your system.
5. Do not eat for 1 hour before or 1 hour after treatment.
6. Use the WBV unit for 10 minutes following each RLT treatment to stimulate lymphatic and blood circulation. WBV helps to increase strength, muscle tone and potential benefits for osteoporosis and osteopenia. It may also help increase balance and coordination while decreasing muscle soreness.
7. To maximize results, it is best to lessen or eliminate alcohol, soda and sugar during the treatment process. Alcohol negatively affects the liver which will work against the treatment, lessening the results.
8. Once you have achieved your goal it is important to do regular maintenance.

Risks/Discomfort

RLT treatment is non-invasive, there should be no discomfort. You may feel the warmth of the light. This therapy is suitable for anyone over 18 who does not have the following: Pregnancy, Recent Cancer or Severe Heart Disease. RLT may cause hypo/hyper pigmentation of the skin.

WBV contraindications: pregnancy, pacemakers, severe heart disease, joint replacements, recent surgery, blood clots, diabetes with complications such as neuropathy or retinal damage, epilepsy or migraines, herniated discs, spondylolisthesis, cancer or tumors. If you have any specific concerns, discuss with your primary doctor prior to your treatment.

CANCELLATION POLICY

We require a 24-hour cancellation notice. If no notice is given you may incur a $35.00 no-show fee. Showing up on time is necessary for scheduling purposes.

Purchase and Reservation Policy

Appointments will only be confirmed and allowed up to the amount of pre-paid sessions. All sales are final and non-refundable. We reserve the right to terminate any client's session or package without refunding any monies if the client has broken any terms of policies or any neglect to the equipment. Promotional packages are to be purchased during the designated time of the promotion.

CONSENT TO TREAT

I state that I am of lawful age and legally competent to sign this release. I understand the procedures, alternatives and risks and I have been given the opportunity to ask questions. I understand it is my responsibility to inform the staff if there are any changes to my medical history. I understand the terms herein in contractual and not a mere recital. I have signed this document of my own free act.

I HAVE CAREFULLY READ, UNDERSTOOD AND ACKNOWLEDGE ALL OF THE ABOVE STATEMENTS, LIABILITIES AND I CONSENT TO THE TREATMENT OF RED LIGHT THERAPY AND WHOLE BODY VIBRATION.

CLIENTS NAME CLIENTS SIGNATURE DATE