BioEnergetic Health Client Information Carl Malone, Provider

Name: _____ Phone( ) ___/_____

Address: _____ Apt# _____

City: _____ State:_____ Zip: _____ Date of Birth: _____

Email: _____ Fax: ( ) _____

Occupation: _____ Referred by: _____

In case of emergency: _____ Phone( ) ___/_____

General & Medical Information:

If you answer "yes" to any of the following questions, please explain as clearly as possible.

❑Yes ❑No Have you ever had professional massage?
❑Yes ❑No Do you experience frequent headaches?
❑Yes ❑No Do you have tension or soreness in a specific area?
❑Yes ❑No Do you suffer from back pain?
❑Yes ❑No Do you have high blood pressure?
❑Yes ❑No Do you have numbness or stabbing pains anywhere? If yes, please explain below.
❑Yes ❑No If yes to the previous question, are you explain in taking medication for this?
❑Yes ❑No Do you have any other medical condition that / should be aware of?
❑Yes ❑No Do you suffer frequently from stress?
❑Yes ❑No Are you pregnant?
❑Yes ❑No Do you have cardiac or circulatory problems?
❑Yes ❑No Are you diabetic?
❑Yes ❑No Are you very sensitive to touch /Pressure in any area?
❑Yes ❑No Do you suffer from seizure disorders or epilepsy?
❑Yes ❑No Have you had any broken bones in the past two years?
❑Yes ❑No Have you ever had surgery? If yes, please explain below.

Comments: _____

_____

Caution

This informed consent warns you that certain procedures are "unproven." Do not sign it until you have read it and had the procedure explained to you, and until you have received answers to any questions you may have. The following procedure, protocol, analysis or methodology has been determined as "unproven" and/or "experimental" using guidelines established by the Colorado State Board of Chiropractic Examiners. Its effectiveness has not been demonstrated.

I, _____, understand that the above referenced procedure, protocol, analysis or methodology has been designated as "unproven" and/or "experimental" using the guidelines by the Colorado State Board of Chiropractic Examiners, and that its effectiveness has not been demonstrated. I hereby consent to the use of: **Low Level Light Therapy (Cold Laser)**

Client/Parent
Signature: _____ Date: _____