RIVER STONE
Massage & Wellness Centre

Date _____

LASER PHOTOBIOMODULATION

Confidential Patient Case History Form

Name: _____ Gender: _____

Address: _____ City: _____ Postal Code: _____

Email: _____ Birthdate: (Day)_____ (Month)_____ (Year)_____

Occupation: _____ Home Phone: _____ Cell Phone: _____

Medical Doctor: _____ Doctor Phone #: _____

How did you hear about us? (check one below)

❒ Google ❒ Facebook ❒ Instagram ❒ Storefront Sign ❒ River Stone Therapist: _____

❒ World Weight Loss Inc. ❒ Doctor or lawyer: _____ ❒ Other: _____

I agree that River Stone Massage may notify me of new treatments and promotions via email. ❒ Yes ❒ No

For what condition or reason are you seeking treatment today? _____

_____

Are you pregnant? ❒ Yes ❒ No

Laser Therapy Contrindications:

Pregnancy — LED treatments are safe. Laser (3B) treatments may be performed except over the belly and lower back.

Cancer — LED and Laser (3B) treatments will not be performed over any cancer. Supportive therapy eg. pain relief and lymphatic drainage may be performed.

Eyes — LED treatments are safe. Lasers (3B) are potentially harmful if viewed directly.

Precautions:

Photo-sensitive medications — Patients taking medications which cause photo-sensitive reactions should advise the laser technician.

I acknowledge that no assurance or guarantee has been provided as to the results of the treatment. I understand that the Laser Technician must be fully aware of my existing medical conditions. I have completed my medical history form as provided by River Stone and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Laser Technician updated on my medical history. I give consent for my treatment notes to be read by the other health care professionals at River Stone. The information I have provided is true and complete to the best of my knowledge.

For insured clients:
I hereby consent to direct billing so that River Stone Wellness Centre may bill my health insurance company and have that company pay River Stone directly for my treatments. By signing this I also state that I will pay any outstanding fees for treatments received that are not covered by my insurance company.

_____ _____ _____

Signature Date Technician Signature