

Patient Intake & Health History

Legal name

Date of birth

Address

Phone

Email

Emergency contact / relationship

Emergency phone

Services requested

☐ Chiropractic care

☐ Contour Light Therapy

☐ Both

Main concerns / reason for visit

When did symptoms begin?

Pain level (0-10), if applicable

Current medications and supplements

Allergies (including topical products)

☐ Pregnant / possibly pregnant

☐ Implanted electronic device

☐ Cancer or active cancer treatment

☐ Photosensitivity / light sensitivity

☐ Seizures or neurological disorder

☐ History of vascular disease / stroke

☐ Osteoporosis / fracture history

☐ Recent surgery / injury

Other conditions, surgeries, or important health information

Clinical Screening & Treatment Preferences

Chiropractic symptom screening

- | | |
|--|--|
| ☐ Neck pain / headaches | ☐ Back pain |
| ☐ Arm / hand numbness or weakness | ☐ Leg / foot numbness or weakness |
| ☐ Dizziness / visual changes | ☐ Recent trauma / fall |
| ☐ Bowel / bladder changes | ☐ Fever / unexplained weight loss |

Previous imaging, diagnoses, or treatment

Contour Light Therapy screening

- | | |
|--|---|
| ☐ Light-sensitive medication | ☐ Skin condition or open wounds |
| ☐ Recent injections / procedures | ☐ History of heat sensitivity |
| ☐ Currently under medical treatment | ☐ Other concerns about light therapy |

Treatment goals / areas of interest

Other concerns or accommodations

Patient communication and preferences

Please tell the clinician about any change in symptoms, new diagnosis, new medication, pregnancy status, or skin reaction before treatment. A clinician may recommend delaying, modifying, or declining treatment based on your history.

- ☐ I would like to discuss risks and alternatives before treatment.
- ☐ I need an interpreter or other communication assistance.

Preferred contact method / additional notes

Informed Consent — Chiropractic Care

Nature and purpose of care

Chiropractic assessment may include history, physical examination, orthopedic and neurological testing, and referral for imaging or medical evaluation when indicated. Treatment may include spinal or extremity manipulation/adjustment, mobilization, soft-tissue work, stretching, exercise instruction, and other conservative procedures.

Potential benefits and limits

Potential benefits include reduced pain or stiffness and improved mobility or function. Responses vary; no specific outcome, cure, or duration of improvement is promised. Chiropractic care is not a substitute for emergency or necessary medical treatment.

Material risks and possible side effects

Common temporary effects can include soreness, tenderness, stiffness, fatigue, or short-term symptom aggravation. Less common complications may include sprain, strain, rib injury, disc injury or worsening, nerve irritation, numbness, weakness, or fracture, especially where underlying conditions increase risk.

Cervical manipulation has been associated with rare but potentially serious injury to arteries in the neck and stroke. The relationship between manipulation and arterial dissection is not fully established, and dissection may already be developing before treatment. Serious neurological or vascular events can cause permanent disability or death.

Alternatives and choices

Alternatives may include no treatment, watchful waiting, home exercise, physical therapy, medication, medical evaluation, or other appropriate care. I may ask questions, request a different technique, refuse a particular procedure (including neck manipulation), or withdraw consent at any time without penalty.

Patient acknowledgments

I have provided my health history to the best of my knowledge, understand the nature of proposed chiropractic care and its potential benefits, risks, and alternatives, and have had an opportunity to ask questions. I understand that a clinician will discuss any material individualized risks before treatment.

☐ I consent to chiropractic evaluation and appropriate treatment.

☐ I do NOT consent to cervical (neck) manipulation at this time.

Patient / legal representative typed name

Date

Signature (sign after printing, or apply an accepted electronic signature)

Informed Consent — Contour Light Therapy

Nature and purpose of treatment

Contour Light Therapy uses externally applied red and/or near-infrared light as a noninvasive wellness or body-contouring service. The provider will explain the equipment, placement, session length, and intended treatment area. It does not replace medical evaluation, weight management, nutrition, or exercise.

Expected benefits and realistic outcomes

Some people seek this service for appearance or wellness goals. Results are variable and may be temporary; no amount of fat loss, inch loss, weight loss, medical improvement, or other outcome is guaranteed. Photographs or measurements, if used, are for progress documentation and are optional.

Risks, discomforts, and precautions

Possible effects include temporary warmth, redness, irritation, itching, dryness, headache, discomfort, or aggravation of a pre-existing skin condition. Eye exposure to bright light can be uncomfortable or hazardous depending on device specifications; I agree to follow all instructions regarding protective eyewear and positioning.

I will disclose pregnancy or possible pregnancy, active cancer or treatment, photosensitive conditions, light-sensitizing medications, implanted devices, skin wounds, recent procedures, and any other relevant medical conditions. These may require modification, clearance, or postponement. I understand that device-specific contraindications and manufacturer instructions also apply.

Alternatives, voluntary participation, and questions

Alternatives include choosing no light therapy or pursuing clinician-guided nutrition, activity, or other appropriate care. I may stop a session immediately if I experience discomfort. I understand that this is an elective service and that my questions should be answered before treatment.

Acknowledgment and consent

I confirm that I have disclosed relevant health information, understand the described benefits, limitations, potential risks, precautions, and alternatives, and voluntarily consent to Contour Light Therapy as deemed appropriate after screening.

☐ I consent to Contour Light Therapy.

Patient / legal representative typed name

Date

Signature (sign after printing, or apply an accepted electronic signature)

Optional general acknowledgment

I understand that I may request a copy of this form. This consent does not waive any legal rights. The provider will maintain patient information according to applicable privacy requirements.

Clinician / witness name

Date reviewed