Red Light Skin Tightening

Health History Form

Verona Spine & Wellness Center
80 Pompton Ave., 3rd Floor
Verona, NJ 07044 | 973-857-1119

Name: _____ **Date:** _____

Date of birth: _____ **Phone:** _____ **Email:** _____

YOUR GOALS

1. Which area(s) would you like to treat?

☐ Abdomen ☐ Flanks / love handles ☐ Upper arms ☐ Thighs
☐ Buttocks ☐ Face / neck ☐ Other: _____

2. What is your main goal?

☐ Tighten loose skin after weight loss ☐ Improve skin texture / firmness
☐ Reduce the look of cellulite ☐ Other: _____

3. Have you tried any other methods or products for skin tightening before contacting us?

☐ No ☐ Yes ☐ Creams / serums ☐ Radiofrequency ☐ Laser ☐ Microneedling
☐ Ultrasound (HIFU) ☐ Surgery ☐ Other: _____ ☐ Results: _____

4. Are you currently taking, or have you recently taken, a GLP-1 or other weight-loss medication?
(e.g., Ozempic, Wegovy, Mounjaro, Zepbound)

☐ No ☐ Yes - Medication: _____

How long: _____ Approx. weight lost: _____

HEALTH SCREENING

5. Are you pregnant, possibly pregnant, trying to conceive, or breastfeeding?

☐ No ☐ Yes

6. Have you ever had skin cancer or any other cancer, or are you currently in cancer treatment?

☐ No ☐ Yes - Please explain: _____

7. Do you have any of the following? (check all that apply)

☐ Diabetes ☐ Thyroid condition ☐ Heart condition ☐ Pacemaker / implanted device
☐ Autoimmune condition (e.g., lupus) ☐ Bleeding / clotting disorder ☐ None

8. Have you ever had a seizure, or migraines triggered by bright or flashing light?

☐ No ☐ Yes - Please explain: _____

9. Are you sensitive to light, or taking anything that can make you more light-sensitive?
(e.g., Accutane/isotretinoin, retinoids, doxycycline or other antibiotics, St. John's Wort)

☐ No ☐ Yes - Please list: _____

10. Please list all current medications and supplements:

_____

_____

11. Do you currently have any of the following in the area to be treated?

☐ Open wound or cut ☐ Rash, eczema, or psoriasis ☐ Skin infection
☐ Recent sunburn or tanning ☐ New or changing mole ☐ None

12. In the past 3 months, have you had any cosmetic treatment in the area to be treated?

☐ No ☐ Yes ☐ Fillers / injectables ☐ Laser or peel ☐ Surgery / liposuction
☐ New tattoo ☐ Other: _____

13. Is there anything else about your health you think we should know?

_____

Acknowledgment: I confirm the information above is accurate and complete to the best of my knowledge.
I will tell the staff about any changes to my health or medications before future sessions.

Patient signature: _____ **Date:** _____

Reviewed by: _____ **Date:** _____

Red Light Therapy Skin Tightening

Client Forms & Office Policies

Client Information

Please complete all fields. This information is kept strictly confidential.

First Name _____

Last Name _____

Date of Birth _____

Address _____

City _____

State / Zip Code _____

Phone Number _____

Email Address _____

Occupation _____

EMERGENCY CONTACT

Emergency Contact Name _____

Relationship _____

Phone Number _____

Health History Questionnaire

Please check all that apply. This helps ensure your safety during treatment.

If you have any of the conditions below, please inform your provider before treatment begins.

Some conditions may require physician clearance or protocol modifications.

MEDICAL CONDITIONS

- ☐ Pregnant or breastfeeding
- ☐ Epilepsy or seizure disorder
- ☐ Undergoing chemotherapy or radiation
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Open wounds in treatment area
- ☐ Cold sores / herpes simplex
- ☐ Eczema
- ☐ Lupus
- ☐ Recent surgery (within 6 weeks)
- ☐ Pacemaker or implanted medical device
- ☐ Cancer (current or previous)
- ☐ Autoimmune disease
- ☐ Heart disease
- ☐ Blood clotting disorder
- ☐ Active skin infection
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Photosensitivity
- ☐ Other medical condition

RECENT TREATMENTS & MEDICATIONS

- ☐ Cosmetic injections within 2 weeks
- ☐ Chemical peel within 2 weeks
- ☐ Accutane within the past 6 months
- ☐ Blood thinning medication
- ☐ Laser treatment within 4 weeks
- ☐ Microneedling within 4 weeks
- ☐ Prescription retinoids
- ☐ Steroids (oral or topical)

Primary Physician

Current Medications (list all)

Known Allergies

Medications Checklist

Please check any medications you currently take or have taken recently.

MEDICATIONS ASSOCIATED WITH PHOTOSENSITIVITY

- ☐ Anti-Arrhythmic Amiodarone (Pacerone, Cordarone, Aratac)
- ☐ Chlorpromazine (Thorazine, Chloramead, Chlordryprom, Chlor Promanyl, Largactil, Promapar, Promosol, Terpium, Sonazine)
- ☐ Acne Oral Isotretinoin (Accutane, Accure, Ankenormin, Amnesteem, Ciscutan, Claravis, Isohexa, Isotrin, Oratane, Sotret, Roaccutane)
- ☐ Topical Isotretinoin (Isotrex, Isotrexin)
- ☐ Anti-Psychotic Haloperidol (Haldol)
- ☐ Trifluoperazine (Stelazine, Cinazine, Novofurazine, Pentazine, Solazine, Terfluzine, Trifluorin, Tripazine)
- ☐ Anti-Fungal Griseofulvin (Grifulvin)
- ☐ Antibiotics Tetracycline (Helidac, Terra-Cortril, Terramycin, Sumycin, Actisite, Bristacycline, Actisite, Tetrex, Doxycycline, Ciprofloxacin)
- ☐ Norfloxacin (Noroxin, Quinabic, Janacin)
- ☐ Ofloxacin (Floxin, Oxaldin, Tarvid)
- ☐ Nalidixic acid (NegGam, Wintrimel)
- ☐ Ciprofloxacin (Cipro, Ciproxin, Ciprobay)
- ☐ Minocycline (Minomycin, Minocin, Arestin, Akamin, Aknemin, Solodyn, Dynacin, Sebomin)
- ☐ Oxytetracycline
- ☐ Demeclocycline
- ☐ Lymecycline
- ☐ Cancer Methotrexate (MTX, Aminopterin, Ledertrexate)
- ☐ Arthritis Auranofin (Ridaura)

The above drugs are currently the most common medications associated with photosensitivity and are by no means a complete list of all photosensitive medications. Herbs and over-the-counter medications such as psoralen and St. John's Wort can also cause sensitivity to light, so it is important to disclose any and all medications or herbs you are currently taking.

Patient signature: _____ Date: _____

Printed name: _____ Email: _____

Liability Release

Photobiomodulation & Hypervibration Treatments

This client has requested services for Photobiomodulation treatments and Hypervibration session(s).

Photobiomodulation treatments penetrate through the skin, stimulating the transitory pores of the fat cell to open up and the fat cell can expel stored contents resulting in a decrease in fat cell size and supporting weight loss. Hypervibration stimulates lymphatic drainage, muscle contraction, metabolism and energy burning. As such, we require a statement to ensure that there are no known medical contraindications before proceeding with any treatment sessions.

The following are known contraindications to Photobiomodulation:

- Pregnancy or may be pregnant
- Nursing
- Fever
- Alcohol/alcohol abuse
- Certain medications that may cause photosensitivity
- Epilepsy
- Currently undergoing chemotherapy
- Pacemaker/defibrillator
- Photosensitivity/recent fracture
- Any other condition that should be disclosed and listed on the intake form.

I understand that I may experience a mild to moderate warmth from the light on the skin; intense warmth/heat is not normal, and you should notify a staff member immediately and the light paddle will be inspected for proper placement or defect.

Because Photobiomodulation treatment should not be used under certain medical conditions, I affirm that I have stated all of my known medical conditions, and answered all questions honestly. I agree to keep the staff updated as to any changes in my medical profile before the session and understand that there shall be no accountability on the staff's part should I fail to do so.

By signing this form, I give Verona Spine and Wellness Center consent to provide me with Photobiomodulation treatments and Hypervibration sessions and release them from all liability.

Further, I agree to the above statements and agree that there are no contraindications.

Client signature: _____ Date: _____

Printed name: _____ Email: _____

Patient Goals & Considerations

Photobiomodulation Treatment Questionnaire

YOUR GOALS

What are your goals by starting this program?

On a scale of 1 to 10, with 10 being the most committed, how committed are you to this program?

MEDICATIONS

Please list all medications (including prescription, over-the-counter drugs and supplements).

PATIENT CONSIDERATIONS

Most can use photobiomodulation treatments, but there are some special considerations:

- Persons diagnosed with active basal cell carcinoma
- Women who are pregnant should consult their physician before beginning red/NIR light therapy treatments.
- Clients with Epilepsy should consult their physician before beginning red/NIR light therapy treatments.
- Taking medications that cause sensitivity to light (example: tetracycline)

The following medicines are known to cause temporary photosensitivity: Please carefully look over the following list of medications and check off any you have taken in the past 7 days. These medications have been known to cause light sensitivity.

Client Goals

Help us understand what you would like to achieve so we can personalize your treatment plan.

AREAS TO BE TREATED

Please check all areas you would like treated:

- ☐ Face
- ☐ Neck / Decolletage
- ☐ Chest
- ☐ Abdomen
- ☐ Arms (upper)
- ☐ Hands
- ☐ Legs
- ☐ Thighs (inner)
- ☐ Thighs (outer)
- ☐ Buttocks
- ☐ Back
- ☐ Other

PRIMARY GOALS

Please check all that apply:

- ☐ Skin Tightening
- ☐ Fine Lines
- ☐ Wrinkles
- ☐ Skin Texture Improvement
- ☐ Acne Support
- ☐ Scarring
- ☐ Collagen Support
- ☐ General Skin Rejuvenation
- ☐ Weight Loss Support
- ☐ Body Contouring

ADDITIONAL INFORMATION

Describe your main skin concern in your own words (optional)

How long have you had this concern?

Any upcoming events / deadlines?

Informed Consent

Please read carefully before signing.

Red Light Therapy utilizes low-level red and near infrared light intended to support normal cellular function and improve the appearance of skin. This treatment is cosmetic and is not intended to diagnose, treat, cure, or prevent disease.

BY SIGNING BELOW, I UNDERSTAND AND AGREE THAT:

- **Results vary.**
  Individual outcomes depend on skin type, condition severity, lifestyle, and number of sessions completed.
- **Multiple treatments are generally necessary.**
  A series of sessions is typically required to achieve optimal results.
- **Improvement occurs gradually.**
  Results may continue to develop for several weeks after completing a treatment series.
- **Individual healing varies.**
  Your response to treatment may differ from others based on your unique physiology.
- **I have disclosed my medical history truthfully.**
  I understand that withholding relevant health information may affect my safety and results.
- **I may discontinue treatment at any time.**
  I am free to stop treatment at any point without penalty.

POTENTIAL TEMPORARY SIDE EFFECTS MAY INCLUDE:

- ☐ Mild redness
- ☐ Warm sensation
- ☐ Temporary skin sensitivity
- ☐ Dryness

Client Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

HIPAA Acknowledgement

Notice of Privacy Practices

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of our legal duties and privacy practices.

I acknowledge that I have received the Notice of Privacy Practices for Verona Spine & Wellness Center. I understand that this practice may use and disclose my health information for treatment, payment, and healthcare operations as described in the Notice.

Client Signature: _____ **Date:** _____

Photography Consent

Photographs help document your treatment progress and results.

Please initial your authorization below. You may select one or more options.

_____ I authorize photographs for my confidential medical record only.

_____ I authorize before and after photographs for educational and training purposes.

_____ I authorize photographs for marketing purposes including website, brochures, and social media.

I understand I may revoke authorization for future use at any time in writing.

Client Signature: _____ **Date:** _____

Financial Policy

Please review and sign to acknowledge our payment and refund policies.

Payment is due at the time of service.

ACCEPTED PAYMENT METHODS

- ☐ Cash
- ☐ Credit Card
- ☐ Debit Card
- ☐ HSA / FSA (where applicable)

REFUND POLICY

- Because aesthetic services are performed immediately, completed treatments are non-refundable.
- Unused prepaid sessions in a package may be subject to office policy and expiration terms.
- Gift certificates are non-refundable.

Client Signature: _____ **Date:** _____

Cancellation Policy

We value your time and ask that you extend the same consideration to our providers.

- Appointments cancelled with less than 24 hours notice may incur a cancellation fee.
- No-shows may be charged up to 100% of the scheduled treatment fee.
- Late arrivals may require shortening or rescheduling the appointment at provider discretion.

Client Signature: _____ **Date:** _____

By signing each section of this document I confirm that I have read, understand, and agree to all of the above policies and consent forms. I certify that the information I have provided is accurate and complete.