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

Basic Patient Information



Name
-

Date
-

Street Address
-

City
-

State
-

Zip
-

Home Phone
-

Cell Phone
-

Email Address
-

Sex
○ Male ○ Female ○ Other

Birth date
-

Height
-

Weight
-

Marital Status
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation
-

Hobbies
-

How did you hear about us?
-

Health and Wellness History

Are you currently under the care of a physician?
-

Are you taking any medications?
-

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Has your doctor advised you to lose weight?
–

Do you have any dietary restrictions?
○ Yes ○ No

If Yes, Please explain
–

How often do you exercise?
–

What type of exercise?
–

Do you feel stressed?
○ Yes ○ No

Explain
–

Check ALL that apply to you:

- ☐ Pregnant/Might Be Pregnant
- ☐ Epilepsy/Seizures
- ☐ Gastric Sleeve
- ☐ PCOS
- ☐ Diabetes: Type 2
- ☐ Heart Condition
- ☐ Currently Undergoing Chemo
- ☐ GI Issues
- ☐ Photosensitivity
- ☐ Gallbladder Removal
- ☐ Breast Feeding
- ☐ Thyroid Issues
- ☐ Diabetes: Type 1

When was the last time you were at your goal weight?
–

What do you consider to be your ideal weight?
–

How much weight do you want to lose?
–

How many times a year do you diet?
–

What is stopping you from losing weight on your own?
–

What have you tried in the past that has failed?
–

Does your weight problem make you physically uncomfortable?
○ Yes ○ No

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Please describe:
–

Does your weight problem cause physical pain?
○ Yes ○ No

Please describe:
–

Are you embarrassed by your excessive weight?
○ Yes ○ No

Please describe:
–

Does being overweight and unhealthy limit your activities?
○ Yes ○ No

Do you binge eat?
○ Yes ○ No

Do you suffer from uncontrollable cravings?
○ Yes ○ No

Do you feel that food controls you?
○ Yes ○ No

Do you eat because of your emotions?
○ Yes ○ No

Do you eat between meals?
○ Yes ○ No

What do you choose to eat between meals?
–

Briefly describe your eating behaviors:
–

Do you feel your eating behaviors are normal?
○ YES ○ NO

Do you feel tired, run down or out of energy?
○ YES ○ NO

Is successful weight loss a top priority?
○ YES ○ NO

Does your family support your weight loss efforts?
○ YES ○ NO

Can you remember being at your ideal weight?
○ YES ○ NO

What do you remember about it?
–

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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?

-

Please list all medications (This includes prescription, over the counter drugs and supplements)

Medication Name, Dosage, Frequency:

-

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.

Medications Checklist

- ☐ Anti-Arrhythmic Amiodarone (Pacerone®, Cordarone® Aratac®)
- ☐ Chlorpromazine (Thorazine®, Chloramead®, Chlordryprom®, Chlor® Promanyl®, Largactil®, Promapar®, Promosol®, Terpium®, Sonazine®)
- ☐ Acne Oral Isotretinoin (Accutane®, Accure®, Aknenormin®, Amnesteem®, Ciscutan®, Claravis®, Isohexa®, Isotrin®, Oratane®, Sotret®, Roaccutane®)
- ☐ Topical Isotretinoin (Isotrex®, Isotrexin®)
- ☐ Anti-Psychotic Haloperidol (Haldol®)
- ☐ Trifluoperazine (Stelazine®, Clnazine®, 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®, Wintrimyoln®)
- ☐ Ciprofloxacin (Cipro®, Ciproxin®, Ciprobay®)
- ☐ Minocycline (Minomycin®, Minocin®, Arestin®, Akamin®, Aknemin®, Solodyn®, Dynacin®, Sebomin®)
- ☐ Oxytetracycline
- ☐ Demelocycline
- ☐ 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.

Signature

Date Signed
-

Printed Name
-

Email
-

Liability Release

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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 condtions, 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.

Signature	Date Signed
	–
Printed Name	**Email**
–	–