The Colonic Institute & Holistic Health Center

Red Light Therapy Questionnaire

46 West Avon Road, Avon CT 06001 Colonicct.com | 860-481-2702

Name: _____ Date: _____

Date of Birth: _____ Gender: _____

Address: _____ Email: _____

City: _____ Cell Phone: _____

Zip Code: _____

Have you done Red Light Therapy in the past? Y☐ N☐

Are you under a doctor's care? Y☐ N☐

What are you being treated for? _____

Doctor's Name, Office Location, and Phone: _____

_____

What are you hoping to resolve with Red Light Therapy? _____

_____

Contraindications

Please check all that currently apply to you:

- ☐ Pregnant
- ☐ Active Cancer
- ☐ Pacemaker
- ☐ Fever
- ☐ Lupus
- ☐ Porphyria
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hyperthyroidism
- ☐ Taking Diuretics

Please explain anything checked above and date of last occurrence:

_____

Cancellation Policy & Disclaimer

☐ Cancellation or changes to appointment day and time must be made within 24 hours in advance of scheduled appointment. **A $50 fee will be charged if an appointment is missed or cancelled at the last minute.** If you need to change or cancel your appointment, please call or text 860-481-2702. Please do not cancel using email.

☐ This service is not intended to replace the relationship with your primary care provider, and any information we provide is not intended in any way as medical advice. The information covered should be considered as shared information and knowledge from your therapist's education, training, and experience. Your therapist encourages you to incorporate new information along with the effectiveness of your service and the fundamental role of diet, exercise, supplements, and stress management therapy. We encourage you to make your own health care decisions based upon your research and in partnership with your primary care provider. **The information and services provided are not used to prescribe, diagnose, or treat health problems or diseases. Your service is not considered a substitute for medical care.**

☐ I have chosen to have this service within my own will and will in no way blame the therapist at The Colonic Institute for any wrongdoing from the general steps involved in providing this service. I realize that detoxification symptoms may occur and is a natural reaction if it does occur due to the effects of this service.

I have read and understand the above information:

_____ (Signature)