Denver Sports Recovery: Full Body Light Therapy Intake Form

CLIENT INFORMAITON:

Name: _____

How did you hear about Full Body Light Therapy? ___Online Search ___Friend/Family ___Event ___Social Media ___Other
Do you have any illness, injuries, diseases, recent surgeries, cancer, chronic pain? If so, please briefly describe below:

_____

_____

Be advised of the following contraindications with Full Body Light Therapy. Please consult with your doctor before receiving treatment if you have experienced any of the following or have other health concerns:

. -Active Cancer (or within 5 years of remission) -Breast-feeding

What is your goal for therapy? ___Sports Recovery ___Weight Loss ___Chronic Pain
. ___Arthritis/Joint Pain ___Wound Healing ___Skin Condition/anti-aging

How long have you had the condition in which you are using Full Body Light Therapy for?
___Days ___Weeks ___Months ___Years ___N/A

Are there other therapies and treatments you are interested in at Denver Sports Recovery? If so, which services: _

___ Active Release Therapy ___ Dry Needling ___ Muscle Activation Technique

___ Acupuncture ___ Fascial Stretch Therapy ___ Nutrition

___ Chiropractic ___ Kinesiology Taping ___ Physical Therapy

___ Cupping/Scraping ___ Lokte Method ___ Recovery Center

___ Deep Tissue Class IV Laser ___ Massage ___ Whole Body Cryotherapy

Emergency Contact_____ **Relationship**_____ **Phone #**_____

INFORMED CONSENT AGREEMENT AND WAIVER OF LIABLITY:

I am voluntarily participating in the Full Body Light Therapy entirely at my own risk. I knowingly enter into this waiver and release of liability and hereby waive and all rights, claims, or causes of action of any kind.

In the event that any damage to equipment or facilities occurs as a result of my or my family's willful actions, neglect or recklessness, I acknowledge and agree to be held liable for any and all costs associated with any actions of neglect or recklessness. In the event that I should require medical care or treatment, I agree to be financially responsible for any costs and incurred as a result of sure treatment. I am aware and understand that I should carry my own health insurance.

I affirm that I am of the age 18 years or older, and that I am freely signing this agreement. I certify that I have read this agreement, that I fully understand its consent and that this release cannot be modified orally. I am aware that this is a release of liability.

Participants Name:_____ **Date:**_____
Signature:_____

Parent/Guardian Name:_____ **Date:**_____
Signature:_____