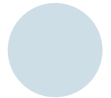
Client Health History: Light-Emitting Diode (LED) Therapy



Name: ____

Address: ______________________________City: ______________State: ________Zip:__________

Home/Cell Phone: ________________________ Work Phone: ________________________________

Email: ___________________ How should we contact you? Home/Cell Phone: __ Work Phone: __ Email: __

When is the best time to contact you? Morning: __ Daytime: __ Evening: __

How did you hear of us? ___________________ Emergency contact name: _______________________

Phone: ________________________ Relationship to you: __________________________________

Health History

Please list any allergies you have: ____

____

Please list all current medications you are taking (including oral and topical prescriptions, over-the-counter herbs, vitamins and supplements):____

____

These questions are relevant to your skin health and may be contraindications for treatment. Please answer thoroughly.

Question	Y	N	Details *If applicable*	Adverse Reactions? *If applicable*
Are you pregnant or nursing?				
Do you wear contacts or glasses?				
Do you have any heart problems?				
Do you have high/low blood pressure?				
Do you currently have any open wounds?				
Have you ever been diagnosed with epilepsy?				
Do you have an autoimmune disorder or connective tissue disease?				
Have you had any previous facial treatments?				
Do you use Retin-A®, Accutane® or any other prescribed topical Vitamin A derivative?				
Do you use any medications that cause light sensitivity?				

Any other health condition not listed: ____

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Is there anything else we should know about? ____

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