AcuLaser TREATMENT CENTRE

The following information is required prior to beginning your therapy. All information is confidential. E-mail is used solely for follow-up support and will not be sold to third parties.

# ******* STRESS RELIEF INTAKE *******

| **Date:** | **First Name:** | **Last Name:** |
|---|---|---|
| **Address:** | | **City:** |
| **State** | **Zip Code:** | **Telephone:** |
| **E-mail:** | | |

**How did you hear about AcuLaser?** ☐TV ☐Radio ☐ Newspaper ☐ Magazine ☐ Internet ☐ Doctor ☐ Friend

**Name of Doctor, Friend or Publication:**

**Do you consider yourself to be in good health?** ☐ Yes ☐ No ☐ Somewhat

**Do you have or ever had any of the following?**

☐ Stents ☐ Allergies ☐Nausea ☐COPD ☐ Insulin ☐ Epilepsy ☐Light sensitivity
☐ Insulin intake ☐ Metal implants ☐ Electrical implants ☐Circulatory problems ☐Cancer _____
☐ Heart condition ☐ Chemotherapy ☐ Kidney disease ☐Other:_____

**Are you pregnant or trying become pregnant?** ☐ Yes ☐ No

**Are you presently taking any medication?** ☐ Yes ☐ No If yes, please specify:

| | |
|---|---|
| Drug: | Reason: |
| Drug: | Reason: |
| Drug: | Reason: |
| Drug: | Reason: |

I, the undersigned, certify that all of the above information is true, and I have not omitted any pertinent information. I am in good physical condition. I am not/nor may be pregnant. I have been informed and understand the nature of the therapy and agree to receive the procedure by a certified laser technician. I agree to hold AcuLaser Treatment Centre harmless of any and all liability arising from or related to acts of omissions of this procedure. I understand that the information is confidential and proprietary to AcuLaser Treatment Centre. I further understand that no guarantee can or is made or implied as the success of the procedure. I understand that the procedure is non-medical and is not covered by any medical insurance plan. I understand that the procedure is complementary therapy and is not meant to replace medical care, and agree to consult my doctor prior to beginning any diet or exercise program. AcuLaser Treatment Centre does not diagnose or treat disease. I certify that I am over 18 years of age and do not have any medical conditions which make low level laser treatment inadvisable. I agree to follow the post-treatment instructions to the best of my ability.

| **Signature:** | **Date:** |
|---|---|

**Are you usually a relaxed person?** ☐ Yes ☐ No

**Are you usually tense or nervous?** ☐ Yes ☐ No

**How do you typically deal with daily stress?**

**What are the most important things in your life?**

**How do you think that stress can jeopardize your ability to achieve the things you mentioned above?**