

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 <i>If applicable</i>	Adverse Reactions? <i>If applicable</i>
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: _____

Is there anything else we should know about? _____
