Patient Information

Full Name: _____

Phone Number: _____

Email Address: _____

Date of Birth: ____ / ____ / _____ **Gender:** ☐ Male ☐ Female ☐ Non-Binary/Gender Diverse

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

How did you hear about us?

☐ Website/Google ☐ Social Media ☐ Friend/Family ☐ Other: _____

Emergency Contact Information

Name: _____

Phone Number: _____

Relationship: _____

Please list your three primary complaints and rate the severity of each

(0 = No pain/discomfort, 10 = Worst pain/discomfort imaginable).

If there are no complaints, please list what benefits you are looking for.

_____ ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

_____ ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

_____ ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Signature & Consent

I acknowledge that I am voluntarily seeking Red Light Therapy at Shift Health Center/Northern Michigan Weight Loss. I understand that this is a non-invasive wellness treatment and does not replace medical care.

Patient Signature: _____ **Date:** ____ / ____ / _____

Guardian Signature: _____ Date: ____ / ____ / _____