New Patient Intake Form

Purpose of Today's Visit

1. Full examination, which includes appropriate diagnostic testing and lab work if necessary.

I consent to receiving a health screening. I acknowledge that I am receiving a demonstration only and agree to hold harmless the facility, owners, employees and any subsidiaries from any damage resulting from this demonstration. I understand and accept that visual documentation (photo and/or video) is necessary for evaluation, program monitoring and marketing. I hereby release and hold harmless this clinic and invisa-RED™ Technology from any reasonable expectation of privacy or confidentiality associated with the images and/or videos specified above. I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type.

Print Name: ____

Signature: ____ Date ________________

New Patient Interview

Print Name	
Adrress	
Phone	Email
Date of Birth	Gender: Female Male
Maritial Status. Married	Single
Group ID:	Insurance Provider Member ID:

Current Medical Condition, Disorders and Diseases

______ Cancer	______ Epilepsy	_____ Thyroid
______ Cardiovacular	______ Insulin Dependent	_____ Kidney
______ Vascular	______ Skin	_____ Hypertension
______ Autoimmune	______ Endocrine System	_____ Sleep Apnea
______ Pregnant / Nursing	______ Tattoo with metallic ink	_____ HIV
______ Orthostatic Hypotension	______ Chronic Regional Pain Syndrome	_____ Liver
______ Surgical Implanted Electro-stimulation Device		_____ Mechanical Injury
______ Use of Medication that causees Photo-Sensitivty		

Please check all symptoms that have applied to you in the last 60 days.

______ Headache	_____ Digestive problems	_____ Depression / Anxiety
______ Fatigue	_____ Irritable	_____ Shortness of Breath
______ Sleeping difficulties	_____ Leg / Foot pain	_____ Chest Pain
______ Restricted activities	_____ Inability to loss weight	_____ Fatigue
______ Back / Neck pain	_____ Stress	_____ Burning
______ Bowel or Bladder Problems	_____ Rapid Heartbeat	_____ Dizziness
______ Numbness and Tingling	_____ Heart Intolerance	_____ Lack of coordination
_____ Syncope (Fainting or Passing Out)	_____ Skin, Hair, or Nail change	_____ Exercise intolerance
_____ Extreme Sensitivity to touch, even Light Touch	____ Muscle Weakness or Paralysis	
_____ Other		

Please Answer the Following Questions

Do you smoke?	Yes	No	If yes how many packs per week?
D you do Drugs?	Yes	No	If yes what kind and how many times?
Do you drink Alcohol?	Yes	No	If yes how many drink per week?