Naturally Unbridled Wellness LLC

FIREFLY PHOTON THERAPY INTAKE FORM

Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Email: _____ Male ☐ Female ☐

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Emergency Contact & Phone: _____

Occupation: _____ Referred by: _____

Are you currently nursing or pregnant: ☐ Yes ☐ No

TOP 2 WELLNESS GOALS (Why Firefly Therapy?): _____

Firefly therapy uses light packets called Photons to enhance blood circulation and alleviate pain in the affected area, aiding in reducing symptoms of soft tissue injuries like swelling. This therapy reduces healing time for superficial injuries such as burns, cuts, and contusions by promoting localized circulation and pain relief. Light therapy emits a specific light bandwidth that triggers biological responses like increased circulation and pain reduction. The therapy focuses on pain reduction and boosting circulation as per FDA clearance and is non-invasive. Notify the technician of any changes in medical history, including pregnancy or new diagnoses.

What are you trying to accomplish with Firefly?

- ☐ Less Pain
- ☐ More Energy
- ☐ Digestive Balancing
- ☐ Emotional Balance
- ☐ Fertility Support
- ☐ Autoimmune Disease
- ☐ Recovery from Illness or Injury
- ☐ Allergy Support
- ☐ Urinary Issues (kidney/bladder)
- ☐ Neurological Support
- ☐ Better Sleep
- ☐ Improved Mood
- ☐ Weight Optimization
- ☐ Clearer Thinking
- ☐ Lyme Disease or Other Infection
- ☐ Female Hormone Support
- ☐ Skin Issues (rash, acne, etc.)
- ☐ Healthy Diet & Lifestyle Support
- ☐ Circulatory Issues (Blood pressure, etc)
- ☐ Cancer Support
- ☐ Other: _____

Who is your chiropractor? _____ How many ounces of water have you consumed today? _____

Pharmaceuticals (prescription or over-the-counter) including birth control taken in the last two months: _____

_____

Vitamins & Supplements taken in the last two months: _____

Have you received any COVID vaccines? ☐ Yes ☐ No If yes, how many? _____

How long do you think it will take to reach your wellness goals? _____ Rate your pain on a scale of 1-10: _____
(ONE BEING LOWEST AND 10 BEING HIGHEST.)

Check all that apply:

Do you have: ☐ Seizure Disorder ☐ Pacemaker ☐ Active Bleeding

DIGESTIVE

- ☐ Constipation with or without straining
- ☐ Diarrhea once a month or more
- ☐ Bloating with or without passing gas
- ☐ Heartburn, Reflux, GERD, EOE, Barret's Esophagus
- ☐ Very stinky gas/stool
- ☐ Formed, smooth bowel movements most days
- ☐ Belching
- ☐ Undigested food in stool
- ☐ Greasy food goes right through you
- ☐ IBS or Inconsistent bowels
- ☐ Pain under the right rib cage
- ☐ Diagnosed with digestive condition

SLEEP

- ☐ Fall asleep easily
- ☐ Wake frequently in the night
- ☐ Pets or family disturb sleep
- ☐ Medication, supplements, or alcohol needed
- ☐ CPAP recommended, but not used
- ☐ Sleep 7-9 hours and wake rested
- ☐ Work requires an altered sleep schedule
- ☐ Bladder wakes 1 or more times/night
- ☐ Can't shut off mind
- ☐ Tired upon waking
- ☐ Wake and cannot fall back asleep
- ☐ CPAP used
- ☐ Inconsistent sleep
- ☐ Pain disturbs sleep

How willing are you to make lifestyle changes to improve your situation?

☐ Not Willing ☐ Slightly Willing ☐ Willing ☐ Very Willing

***Please answer the following questions:**

Do you have chronic low blood pressure? ☐ YES ☐ NO

Do you have neuropathy? ☐ YES ☐ NO

Do you have a history of epilepsy? ☐ YES ☐ NO

Do you take any drugs that make you sensitive to light? ☐ YES ☐ NO

Do you have active cancer? ☐ YES ☐ NO

Do you take blood thinners? ☐ YES ☐ NO

Do you have any medical condition which makes you sensitive to light? ☐ YES ☐ NO

Do you have any contagious conditions? ☐ YES ☐ NO

Have you been diagnosed with Fibromyalgia? ☐ YES ☐ NO

Have you ever had a brain injury or concussion? ☐ YES ☐ NO

If you answered "YES" to the brain injury question, how long ago did the injury occur and how severe?

_____

Have you had any surgeries or medical procedures, including breast implants? ☐ YES ☐ NO

If you answered "YES" to surgeries or procedures, what were they for and when did they occur? _____

_____

If you answered YES to any of the above questions, consult with your Health Care practitioner before proceeding with Light Therapy. If you are choosing to proceed with the light therapy sessions, anyway, please sign and date this document.

Printed Name: _____ **Date:** _____

Signature: _____

Naturally Unbridled Wellness LLC, 1285 Rudy Street, Suite 104 Onalaska, WI 54650
608-799-8326 www.NaturallyUnbridled.com

Informed Consent for FIREFLY Photobiomodulation

Firefly Photobiomodulation utilizes packets of light called Photons to stimulate blood circulation to the treatment area. This may result in relief of pain and reduction of symptoms associated with soft tissue injury, such as swelling. Firefly Photobiomodulation may also decrease the healing time associated with superficial injuries, such as burns, cuts, and bruises.

Light therapy is non-invasive. It is important to notify the practitioner if your medical history changes such as becoming pregnant or if you have been newly diagnosed with a medical condition. Please see intake form for more information.

Firefly Light therapy can cause serious damage to the eyes; therefore, it is very important to wear the provided protective glasses at all times during the session.

Although **rare**, the most common adverse effects to Firefly Photobiomodulation are:

- Reactions when photosensitizing drugs are used with Firefly Photobiomodulation
- Temporary dizziness
- Mild bruising from stimulation of blood circulation
- Mild, temporary increase in pain during or in the day(s) following the session

I have read and understand the risks of Firefly Light therapy. I agree to wear the protective glasses provided to me during my entire session.

Signature:_____ Date:_____

Printed Name: _____

Date of Birth: _____

TURN PAGE OVER >>>>

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Informed Consent for PEMF Therapy

Pulse System: Pulsed Magnetic Cellular Exerciser

I _____, hereby request a Pulsed Magnetic Cellular Exercise session. I understand that the Pulse System creates a fully adjustable pulsed magnetic field. I understand that the information shared by the demonstrator are his/her personal opinions and are intended for educational purposes only.

Product Disclaimer

The Pulse System produces magnetic field energy, which passes freely through tissue for the purpose of cellular exercise to promote and support a sense of wellbeing. The FDA has not evaluated the Pulse System. It is not intended for the diagnosis, treatment or cure of any medical condition. The Pulse System is not a medical device and we cannot make any claims that we can affect medical conditions.

We understand this general statement regarding pulsing magnetic fields to be accurate:

" PEMF (pulsed electromagnetic field) devices do not treat a specific condition. Instead they optimize the body's natural self-healing and self-regulating function ."

-- Dr. Magda Havas Associate Professor of Environmental & Resource Studies at Trent University

Do not use if:

- you have an implanted electronic device including: pacemaker, defibrillator, cochlear hearing device, spinal stimulator, etc.
- you are pregnant.
- you are actively bleeding, hemorrhaging, or during heavy menstruation

Before beginning a PEMF Exercise Session we recommend the following:

- remove the following from your person: Electronic or battery operated devices, keys/fobs, wallets, ID and credit cards with magnetic strips such as credit cards and hotel keys, jewelry and hearing aids
- Naturally Unbridled Wellness LLC and our technicians are not responsible for damage to technology that has not been removed prior to your session
- if you are unsure whether pulsed magnetic cellular exercise is right for you, consult with your licensed health care provider(s)

During a PEMF Exercise Session

- if you experience natural reactions that include but are not limited to nausea, headache, fatigue or any uncomfortable sensations we recommend you suspend the session and consult your doctor

Beyond what is stated above, I_____, understand that other risks associated with a pulsed magnetic exercise session are unforeseeable and that the demonstrator, the manufacturer, the marketer, employees, agents and affiliates cannot accept any liability for loss or damages incurred as the result of the Pulse System session. I reserve the right to use the knowledge I have gained in the care of my own body in any legal manner I may choose. I have read this form and voluntarily agree to the Pulse System session on my person assuming all liability for any and all results or consequences.

_____ _____

Signature **Date**

_____

Print Name Clearly

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