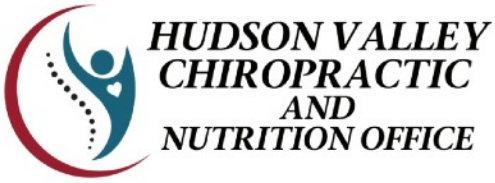

PEMT PATIENT INTAKE FORM

475 Tuckahoe Road Suite 201
Yonkers, NY 10710
Telephone 914-793-1824 Fax 914-793-8654

Disclaimer: Information collected about new patients is confidential and will be treated accordingly.

PATIENT DETAILS

Patient Name: _____ **Date of Birth**: _____
Sex: □ Male □ Female □ Other: _____
Street Address: _____
City: _____ **State**: _____ **ZIP Code**: _____
Home Phone: _____ **Mobile Phone**: _____
Email:_____

Acknowledgement

Pulse Electro Magnetic Treatment (PEMT) massage handle cannot be used for the following situations:
Please initial next to any applicable condition(s) you have and notify the Dr immediately.

1. _____ Pregnant women or breastfeeding
2. _____ Vascular disease
3. _____ Malignant tumors
4. _____ Electronic devices implanted in the body such as pacemakers, steel plates, defibrillators, etc
5. _____ People with blood disease, anticoagulant disorders or those using anticoagulants
6. _____ Children under 14 years old
7. _____ Patients with severe hypertension, severe cardiovascular and cerebrovascular diseases, patients with diabetes, and patients with polyneuropathy
8. _____ Patients with acute inflammation, deep venous thrombosis, goiter, asthma, cancer, etc
9. _____ Patients with epilepsy and seizures

Oxygen content and detoxification increases during PEMF treatment and as toxins leave your body on rare occasions few people may experience dizziness, nausea, headaches, or muscle pains. (Extremely rare as PEMF is earth's energy.)

By signing below, I hereby acknowledge, agree, and authorize all of the following:

Consent for Treatment. I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.

Patient Signature: _____ **Date**: _____

Print Name: _____