



CELLUMA® LED LIGHT THERAPY

CLIENT INTAKE & HEALTH SCREENING

CLIENT INFORMATION

Client Name: _____ **Email:** _____
Appo. Date: _____ **Time Slot:** _____ **Phone:** _____

TREATMENT REQUESTED

☐ AGING ☐ ACNE ☐ CONTOUR ☐ PAIN Treatment Area: _____

CELLUMA CONTRAINDICATIONS

Please answer every question. If you answer YES to any question, tell your Sunrise Spa technician before treatment. Treatment may need to be postponed, changed, or declined depending on the Celluma mode and current manufacturer instructions.

- ☐ I am pregnant or breastfeeding AND the proposed treatment area includes my breast or stomach.
- ☐ I am an infant or child.
- ☐ I have epilepsy or a history of seizures.
- ☐ I am currently receiving cortisone injections or another steroid injection.
- ☐ I have a known cancerous tumor or metastasis in or near the proposed treatment area.
- ☐ CONTOUR Mode: my BMI is greater than 40 kg/m².

If YES to any item above, please explain: _____

CLIENT INTAKE & HEALTH SCREENING

ADDITIONAL SAFETY SCREENING

- ☐ I have a condition that makes me unusually sensitive to light (photosensitivity).
- ☐ I take a medication or use a topical product that may increase light sensitivity.
- ☐ I have an active skin infection, open wound, severe irritation, unexplained rash, or sunburn in the treatment area.
- ☐ I have been advised by a healthcare provider to avoid light-based treatments.
- ☐ I have had an unusual reaction to a previous light-based treatment.
- ☐ I have another medical condition or circumstance that may affect LED light therapy.

If YES to any item above, please explain: _____

MEDICATIONS, SUPPLEMENTS & TOPICAL PRODUCTS

List medications, supplements, prescription drugs, or topical products you currently use that may be relevant to light sensitivity. Do not stop a prescribed medication in order to receive LED therapy. _____

CLIENT CONSENT • ACKNOWLEDGMENT & RELEASE

WHAT I UNDERSTAND

- ☐ I have been informed that Celluma LED Light Therapy is a non-invasive, low-level light treatment and that individual results vary.
- ☐ I understand that no specific result has been guaranteed to me.
- ☐ I have provided accurate and complete information about my health, medications, skin condition, and other relevant circumstances.
- ☐ I understand that Sunrise Spa personnel do not diagnose medical conditions or prescribe medication.
- ☐ I understand that I may stop the treatment at any time and should immediately report discomfort or unusual symptoms.
- ☐ I agree to follow all treatment, positioning, and eye-safety instructions given by Sunrise Spa personnel.
- ☐ I understand that the Celluma manufacturer's current instructions for use and safety requirements apply to the device and treatment.

POSSIBLE TEMPORARY EFFECTS

I understand that possible temporary effects may include warmth, mild redness, sensitivity, dryness or tightness, eye discomfort from bright light, headache, temporary irritation, or other individual reactions. Individual responses vary.

EYE SAFETY

I understand that the LED light may be bright. I agree to use the eye protection provided or follow my technician's instructions regarding closed eyes and positioning. I will immediately tell my technician if the light causes discomfort.

CONSENT & RELEASE

I voluntarily request Celluma LED Light Therapy at Sunrise Spa. I understand that, like any cosmetic or wellness service, the treatment has inherent risks and individual responses cannot be guaranteed. To the fullest extent permitted by applicable Florida law, I release and hold harmless Sunrise Spa, its owners, employees, independent contractors, technicians, and service providers from claims arising from the ordinary risks of the service, except to the extent liability cannot lawfully be waived, including liability for gross negligence, reckless conduct, or intentional misconduct. I understand that this document does not waive rights that cannot legally be waived.

I have read this form, understand its contents, have had the opportunity to ask questions, and voluntarily consent to treatment.

Full Name: _____ **Client Signature:** _____ **Date:** _____

Parent / Legal Guardian: _____ **Guardian Signature / Date:** _____

SUNRISE SPA STAFF REVIEW

- | | |
|---|--|
| ☐ Health screening reviewed | ☐ Contraindications reviewed |
| ☐ Treatment area appropriate | ☐ Eye-safety instructions given |
| ☐ Client questions answered | ☐ Treatment approved / postponed as appropriate |

Technician Name: _____

Technician Signature / Date: _____



CELLUMA® LED LIGHT THERAPY

TREATMENT RECORD • TECHNICIAN USE

CLIENT / APPOINTMENT

Client Name: _____ Date / Time: _____ Technician: _____

MODE & TREATMENT

☐ AGING ☐ ACNE ☐ CONTOUR ☐ PAIN Treatment Area: _____

Treatment Duration: _____ minutes Device / Serial No. (if tracked): _____

PRE-TREATMENT SAFETY CHECK

- | | |
|--|--|
| ☐ Client consent on file / current | ☐ No new contraindication reported |
| ☐ Medication / photosensitivity status reviewed | ☐ Skin condition suitable for treatment |
| ☐ CONTOUR BMI restriction reviewed when applicable | ☐ Eye-safety instructions reviewed |
| ☐ Pregnancy / breastfeeding and treatment area reviewed when applicable | ☐ Treatment area checked |

TREATMENT NOTES

CLIENT RESPONSE

- | | | |
|---|---|--|
| ☐ Comfortable throughout | ☐ Eye discomfort | ☐ Skin irritation |
| ☐ Mild warmth | ☐ Headache | ☐ Mild redness |
| ☐ Other: _____ | | |

Technician Signature: _____ Date / Time: _____



CELLUMA® INCIDENT / ADVERSE REACTION REPORT

INCIDENT INFORMATION

Client Name: _____

Date / Time of Incident: _____

Technician: _____

Celluma Mode: _____

Treatment Area: _____

WHAT HAPPENED?

Describe the client's complaint, observed reaction, or other incident objectively. Do not diagnose.

IMMEDIATE ACTIONS TAKEN

☐ Treatment stopped

☐ Device removed / turned off

☐ Client repositioned

☐ Cool compress offered

☐ Eye protection checked / replaced

☐ Client advised to seek medical evaluation

☐ Emergency services contacted

☐ Other: _____



CELLUMA® LED LIGHT THERAPY • CLIENT AFTERCARE

AFTER YOUR TREATMENT

Celluma LED Light Therapy is non-invasive and typically requires little or no downtime. Follow the instructions provided by your Sunrise Spa technician and the Celluma manufacturer's current instructions for use.

WHAT YOU MAY NOTICE

A temporary feeling of warmth or mild redness may occur. Some clients may experience temporary sensitivity, dryness, tightness, headache, or eye discomfort. Report concerning or persistent symptoms to Sunrise Spa and seek medical advice when appropriate.

AFTERCARE REMINDERS

- ☐ Follow any skin-care instructions provided for your specific treatment.
- ☐ Avoid introducing new or potentially irritating products immediately after treatment unless advised otherwise.
- ☐ Use sun protection appropriate for your skin and treatment.
- ☐ Do not discontinue prescription medications based on this form.
- ☐ Contact a healthcare professional for severe, persistent, or unusual symptoms.

CLIENT ACKNOWLEDGMENT

I received an opportunity to ask questions and understand the aftercare information provided to me.

Client Signature: _____ Date: _____

SUNRISE SPA CONTACT

Sunrise Spa • 5750 5th Ave N • St. Petersburg, FL 33710 • 727-360-4300 • www.mysunrisespa.com