

LIGHT THERAPY SYMPTOM SURVEY

NAME: _____ DATE: _____

ARE YOU CLAUTSTOPHOBIC (Y / N)

DO YOU HAVE LIGHT SENSITIVITY WITH SKIN OR EYES? (Y / N)

ALLERGIES _____

MEDICATIONS _____

DESCRIBE YOUR SLEEP QUALITY _____

ARE YOU MANAGING ANY MENTAL HEALTH ISSUES? (Depression, anxiety, ADD, ADHD, PTSD)?
If yes, explain: _____

DIGESTIVE/GI ISSUES (Y / N) If yes, explain _____

INJURIES/SURGERIES _____

DO YOU HAVE ANY MUSLE KNOTS OR TRIGGER POINTS (Y / N)? If yes, explain where: _____

WOMEN—Any menstrual cycle issues, pain? _____

OTHER --Something you have been able to do in past but not now because of current issue: _____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS	
YES / NO	Do you have chronic low blood pressure?
YES / NO	Do you have a history of epilepsy or seizures?
YES / NO	Do you have active carcinoma (cancer)? If so, where?
YES / NO	Do you take blood thinners?
YES / NO	Do you take nitrates such as nitroglycerin?
YES / NO	Do you have any areas of hemorrhage (active bleeding)?
YES / NO	Are you currently pregnant or breastfeeding?
YES/NO	Are you prone to sun spots, brown discoloration of skin, melanocytes, melasmas, or have darker pigmented skin?
YES / NO	Do you have contagious or infectious conditions?
YES / NO	Are you diabetic or take insulin?
YES / NO	Have you had a brain injury, concussion, car accident or hit your head? If yes, please describe the event(s) and give the date(s).
IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, THEN YOU ARE NOT A CANDIDATE FOR LIGHT THERAPY	
YES/NO	Do you wish to proceed with treatment and declare you will notify your practitioner of your choice to include light therapy as part of your personal protocol?

Please mark reason for visit:

_____ Pain

_____ Acute Pain (had 0-3 months)

_____ Chronic Pain (had 3+ months)

_____ Neuropathy

_____ Brain Health

_____ Anti-Aging

_____ Muscle Soreness

_____ Muscle Knots

_____ Arthritis

_____ Gastrointestinal (Gut)

_____ Depression, Anxiety, ADD, ADHD, PTSD

_____ Other, explain _____

Medications _____

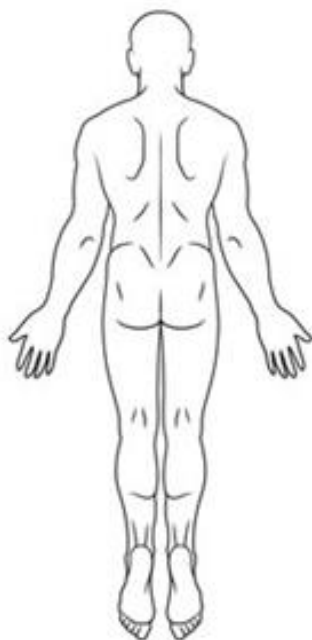
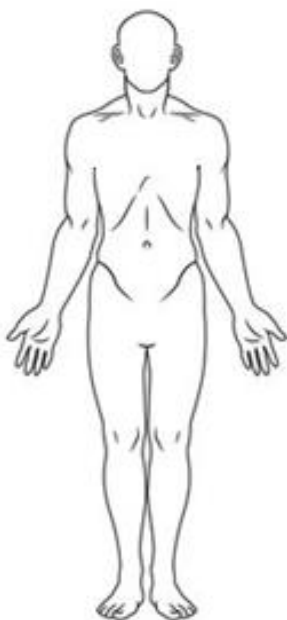
#1 Concern: _____ Pain Rating _____ / _____ How long been an issue? _____

#2 Concern: _____ Pain Rating _____ / _____ How long been an issue? _____

#3 Concern: _____ Pain Rating _____ / _____ How long been an issue? _____

(Before /After session)

Please mark area (s) of



Pain Assessment Scale

- ① ② **MILD/MINOR**
Pain ranges from barely noticeable to annoying with occasional twinges.
- ③ ④ **UNCOMFORTABLE / MODERATE**
Pain ranges from noticeable to distracting but can be ignored for periods of time.
- ⑤ ⑥ **DISTRACTING / DISTRESSING**
Moderately strong pain that likely interferes with normal activity and concentration.
- ⑦ ⑧ **SEVERE / INTENSE**
Dominant pain that interferes with sleep & significantly limits daily activities.
- ⑨ ⑩ **EXCRUCIATING / UNBEARABLE**
Ranges from being unable to converse & moaning/screaming - to bedridden and delirious. Few people will ever experience this level.