LIGHT THERAPY SYMPTOM SURVEY

NAME: ___________________________________ DATE: ____________________

ARE YOU CLAUTSTROPHOBIC (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 MUSCLE 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 ____

____

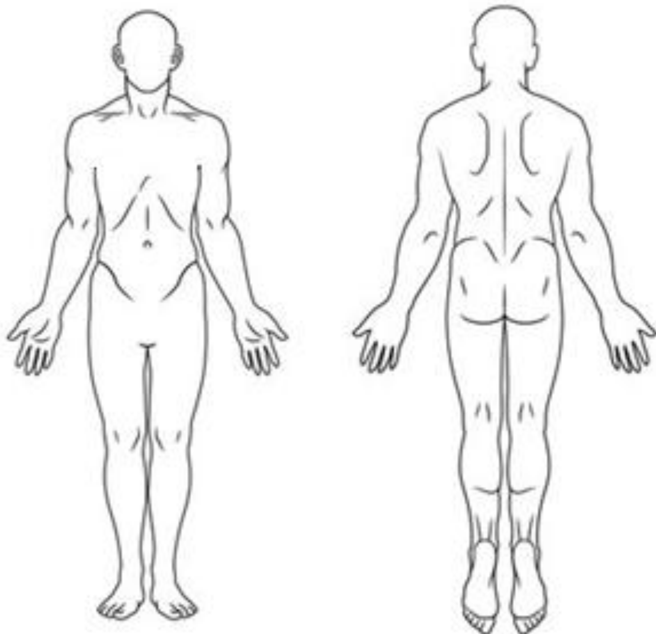
#1 Concern: ________________________ Pain Rating ______ /______ How long been an issue? __________

#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 noticable to annoying with occasional twinges.

③ ④ UNCOMFORTABLE / MODERATE
Pain ranges from noticable 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.