



## Red Light Therapy Intake Form

Full Name: \_\_\_\_\_ Called Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_

Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Widowed \_\_\_ Divorced Sex: \_\_\_ M \_\_\_ F

Occupation: \_\_\_\_\_

Who may we thank for referring you to our office?

Friend/Family: \_\_\_\_\_ Health Care Provider: \_\_\_\_\_

Online Search: \_\_\_\_\_ Wellness Class: \_\_\_\_\_ Other: \_\_\_\_\_

### **Medical History**

**Do you or any family member have/had any of the following? Please put an "X" for you, and a "F" for family.**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Brain Fog           | <input type="checkbox"/> Headache                  |
| <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Hypoglycemia        | <input type="checkbox"/> Poor Sleep                |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Dizziness                 |
| <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Arthritis                 |
| <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Weight Gain               |
| <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Intestine Problems  | <input type="checkbox"/> Back Pain                 |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Carpal Tunnel             |
| <input type="checkbox"/> Fatigue             | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Neuropathy/Nerve Problems |

**Is there a certain time of day any of these problems are worse?**

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**Are you taking any medications/supplements? If yes, please list.**

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**Are you pregnant? \_\_\_\_\_ How many children? \_\_\_\_\_ How many pregnancies? \_\_\_\_\_  
Are you breastfeeding? \_\_\_\_\_**

**Any known allergies? If yes, please list.**

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**Main Concerns:**

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

**How long have you had this/these concerns?**

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**What effect does this have on your bodily functions or quality of life?**

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**What would be different or better without this/these concerns?**

- |                       |                          |                |
|-----------------------|--------------------------|----------------|
| ___ Diminished Stress | ___ Family               | ___ Confidence |
| ___ Work              | ___ Improved Self-Esteem | ___ Sleep      |
| ___ More Energy       | ___ Outlook              |                |

**How have you addressed weight management in the past?**

\_\_\_ Medications    \_\_\_ Vitamins    \_\_\_ Exercise    \_\_\_ Diet & Nutrition    \_\_\_ Other: \_\_\_\_\_

**How did the previous methods work for you?**

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**What potential barriers do you foresee that would prevent the change you are looking for?**

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**Do you feel it possible to eliminate or prevent these potential barriers?**

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**What outcome would you like to see for this to be a success for you?**

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**Please rate on a scale of 1-10 ( 1 being the lowest and 10 being the highest)**

Energy Level	1	2	3	4	5	6	7	8	9	10
Quality of Sleep	1	2	3	4	5	6	7	8	9	10
How Important It is For you to resolve Your health concerns	1	2	3	4	5	6	7	8	9	10
What is your level Preparedness to Make necessary Lifestyle changes to achieve your goals?	1	2	3	4	5	6	7	8	9	10

**I am interested in:**

- Weight Loss                       Anti-Aging                       Long-Term Results  
 Inch Loss                               Metabolism Support

**Quality of Life Survey**

Please take several minutes to answer these questions so we can help you get better.  
**(Please check all that apply)**

**How have you taken care of your health in the past?**

- Medications                               Nutrition/ Diet  
 Emergency Room                               Holistic Care  
 Routine Medical                               Vitamins  
 Exercise                                       Chiropractic  
 Other (please specify): \_\_\_\_\_

**How did the previous method(s) work out for you?**

- Bad Results                                       Did not get worse  
 Some Results                                       Did not work very long  
 Great Results                                       Still Trying  
 Nothing Change                                       Confused

**How have others been affected by your health conditions?**

- No one is affected                                       They tell me to do something  
 Haven't noticed any problem                                       People avoid me

**What are you afraid this might be (or beginning) to affect (or will affect)?**

- |                                   |   |                                      |
|-----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Job      | <input type="checkbox"/> Sleep          | <input type="checkbox"/> Time        |
| <input type="checkbox"/> Kids     | <input type="checkbox"/> Future Ability | <input type="checkbox"/> Finances    |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Freedom        | <input type="checkbox"/> Self-Esteem |

**Are there health conditions you are afraid this might turn into?**

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> Family Health Problems | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Heart Disease   |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Need Surgery | <input type="checkbox"/> Arthritis       |

**How has your health condition affected your job, relationships, finances, family or other activities? Please give examples:**

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**What has that cost you? (Time, money, happiness, freedom, sleep, promotion, etc.?)  
Give 3 examples:**

1. 

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2. 

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3. 

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**What are you most concerned with regarding your problem?**

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**Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.**

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**What would be different/better without this problem? Please be specific.**

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**What do you desire most to get from working with us?**

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**What would that mean to you?**

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