BioLight Low Level Laser Intake

Name: _____ **Date:** _____

List any Medications or Supplements:

_____

_____

Check the box to indicate any medical conditions you currently have:

☐ Pregnancy	☐ Allergies	☐ Arthritis/Tendonitis
☐ Cancer	☐ Headaches or TMJ	☐ Immune Disorders
☐ Heart/circulation problems	☐ Depression/ Anxiety	☐ High/Low blood pressure
☐ Recent accident/ surgery	☐ Varicose veins	☐ Blood clots
☐ Neck/ Back injuries	☐ Diabetes	☐ Fibromyalgia
☐ Numbness or Swelling	☐ Sprains/strains	☐ Osteoporosis

Explain any conditions you have marked above:

_____

_____

_____

_____

Do you have sensitivity to? _____Touch _____Cold or Heat _____Dry or Damp
Are you wearing? ____Contact lens ____Hearing Aids _____Dentures _____IUD _____Pacemaker
Have you had any? _____Surgeries; _____ Injuries or _____ Other conditions not listed?

Personal Issues or Concerns:

List and rate your issues/concerns on a scale of 0-5 (0 = no issue, 5 = worst imaginable)

	Issues/Concerns	Rating
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Your signature below indicates that have provided accurate information.

Client Signature: _____ Date: _____

Client Name (printed): _____