CLIENT PROGRESS TRACKING

Name: _____ Age: _____ Phone: _____ Date: _____

Reported Issue(s): Pain ___ (Acute / Chronic) Circulation ___ Neuropathy ___ Brain Health ___ Athletic ___ Anti-Aging ___
Other _____

Response to Sessions:

Were any significant improvements reported by the completion of the final session?

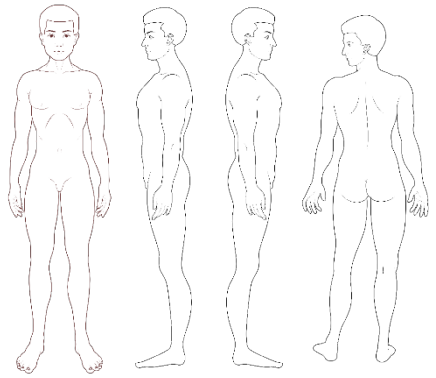
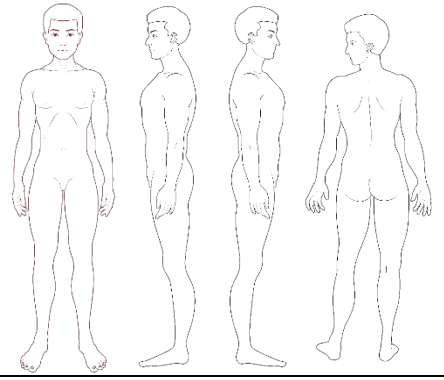
Which types of Light Applications triggered the most improvement?

Has the client's emotional state changed or improved?

Did the client experience any negative responses? (pain, itching, headaches, etc.)

Is the client continuing with Light Therapy or Photopuncture? If Yes, what is your plan moving forward?

Name: _____ Date: _____

Session #	Session Date	Description of Session Lights Used, Response to Lights, Changes Reported	Pain/QOL before / after	Where did you apply the lights?
1				
2				
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