CLIENT SESSION FORM

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

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

Client Description of Issue(s): _____

_____

_____

_____

Quality of Life tracking: What would be an indication that Light Therapy is working for them?
Initial QOL Score? ___ at 2 hours ____ at 24 hours ____ Emotional State _____ On medications? ___

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.

Reported Area(s) of Pain or Concern		Pain before	Pain after	Pain 2 hrs	Pain 24 hrs
1					
2					
3					
4					
5					
6					

Name: _____ Date: _____

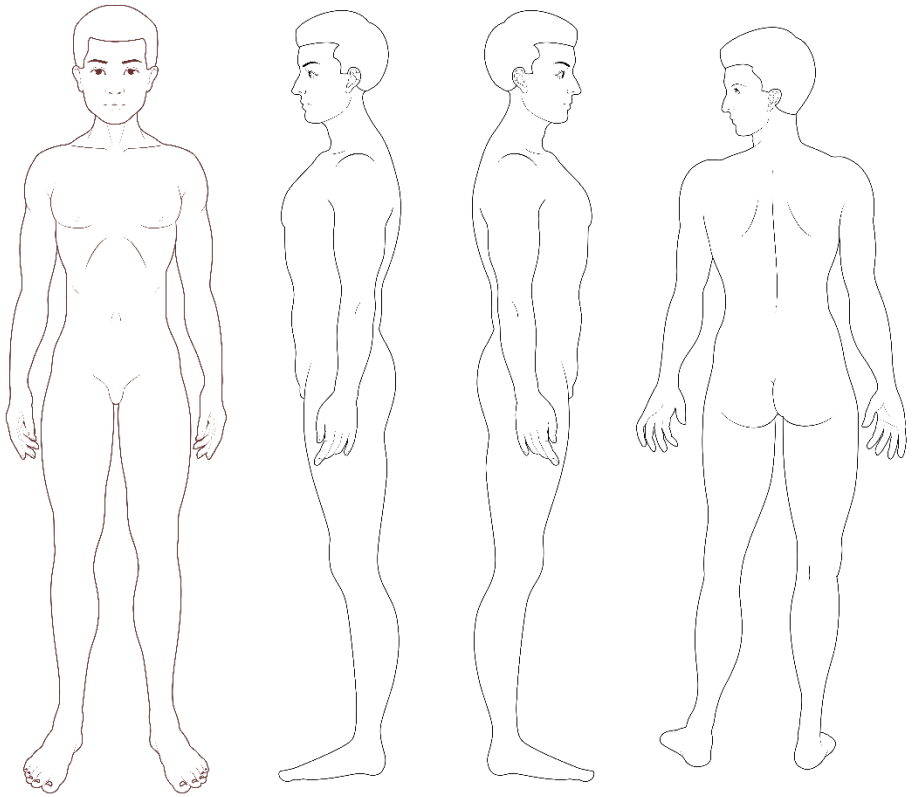
Response to Session: _____

_____

_____

_____

_____



Have client circle areas of concern. List each area, tools used, and response to the Lights for that area in the table to the right.

Area(s)	Description	Feedback
	Equipment, Setting, Time	