BIO Light Therapy
Wellness Through Light

172 E. Merritt Street
Prescott, AZ 86301
408-333-9821

Patient Intake Form

Patient Name	Date
Date of Birth	
Address	Email:
	Telephone
Primary Health Provider	Contact Person/Relationship
Medications	
Drug Allergies	Emergency phone number

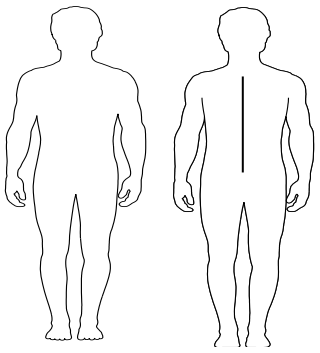
Chronic Medical Problem List	Date	Past Surgical History	Date

Pain Questionnaire

1. Where is your pain?

Site One	Site Two

Write in words or use the pictures to show where you have pain.

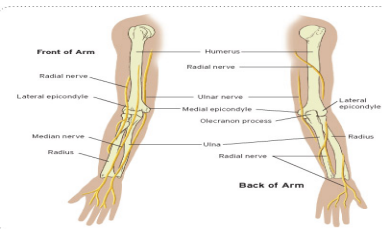


2. Circle the words that describe your pain for Site One:

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable

3. Circle the words that describe your pain for Site Two:

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable



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4. *How did these symptoms begin?*

Site One	*Site Two*

5. *When did you first start experiencing these symptoms? MM/DD/YY*

Site One	*Site Two*

Site One:

1. Rate your pain by circling the number that best describes your pain at its **worst** in the last month.
   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine
2. Rate your pain by circling the number that best describes your pain at its **least** in the last month
   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine
3. Rate your pain by circling the number that best describes your pain on **average** in the last month.
   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine
4. Rate your pain by circling the number that best describes your pain **right now**.
   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine
5. What makes your pain **better**? _____
6. What makes your pain **worse**? _____
7. What treatment or medication are you receiving for your pain? If you are not receiving any treatment or medication, circle NONE.

   None

   _____

8. *Circle the one number that describes how, during the past week, pain has interfered with your*:

   a. General Activity Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

   b. Mood Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

   c. Normal Work Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

   d. Sleep Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

   e. Enjoyment of life Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

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Site Two:

1. Rate your pain by circling the number that best describes your pain at its **worst** in the last month.
   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

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2. Rate your pain by circling the number that best describes your pain at its **least** in the last month
   a. No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine
3. Rate your pain by circling the number that best describes your pain on **average** in the last month.
   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine
4. Rate your pain by circling the number that best describes your pain **right now**.
   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine
5. What makes your pain **better**? _____
6. What makes your pain **worse**? _____
7. What treatment or medication are you receiving for your pain? If you are not receiving any treatment or medication, circle NONE.

   None

   _____

8. *Circle the one number that describes how, during the past week, pain has interfered with your*:

   a. General Activity Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

   b. Mood Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

   c. Normal Work Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

   d. Sleep Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

   e. Enjoyment of life Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

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Plan:

Patient Signature _____ Date: ___/ ___/ _____

Therapist Signature:_____ Date: __/ __/ ____