



## CLOUD 9 CHIROPRACTIC

PERSONAL CARE. MODERN POSSIBILITIES.

2116 Merrick Avenue, Suite 3009 | Merrick, NY 11566  
(516) 665-3766

# Red light therapy intake

## 01 / YOUR INFORMATION & WELLNESS GOALS

Complete the fields, save your copy and bring it to your visit. Check all that apply. You may type your name in the signature field or print and sign by hand.

Full name

Date of birth

Cell phone

Email

☐ Male

☐ Female

Emergency contact & cell phone

Who can we thank for referring you to us?

## Primary goals for red light therapy

☐ Pain relief

☐ Joint health

☐ Energy & fatigue

☐ Skin health & body contouring

☐ Athletic performance & recovery

☐ General wellness

☐ Muscle recovery

☐ Inflammation support

☐ Sleep improvement

☐ Stress reduction / relaxation

☐ Longevity / cellular health

☐ Other

Other goals



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02 / CURRENT HEALTH & MEDICAL HISTORY

## Current health information - check all that apply

- |                                               |                                                       |
|-----------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Chronic pain         | <input type="checkbox"/> Muscle tightness or soreness |
| <input type="checkbox"/> Joint stiffness      | <input type="checkbox"/> Headaches                    |
| <input type="checkbox"/> Fatigue / low energy | <input type="checkbox"/> Poor sleep                   |
| <input type="checkbox"/> High stress          | <input type="checkbox"/> Skin concerns                |
| <input type="checkbox"/> Inflammation         | <input type="checkbox"/> Other                        |

Other current health concerns

## Medical history - select Yes or No

- |                                       |                           |                          |
|---------------------------------------|---------------------------|--------------------------|
| Pregnancy or trying to conceive       | <input type="radio"/> Yes | <input type="radio"/> No |
| History of cancer                     | <input type="radio"/> Yes | <input type="radio"/> No |
| Seizures or epilepsy                  | <input type="radio"/> Yes | <input type="radio"/> No |
| Light sensitivity or photosensitivity | <input type="radio"/> Yes | <input type="radio"/> No |
| Autoimmune condition                  | <input type="radio"/> Yes | <input type="radio"/> No |
| Cardiovascular condition              | <input type="radio"/> Yes | <input type="radio"/> No |
| Skin disorders or conditions          | <input type="radio"/> Yes | <input type="radio"/> No |

If YES to any, please explain



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03 / MEDICATIONS, LIFESTYLE & ACKNOWLEDGEMENT

## Medications & supplements

Are you currently taking any medications or supplements?

☐ Yes ☐ No

If yes, please list

## Lifestyle & wellness

How often do you exercise?

☐ 0-1x/week ☐ 2-3x/week ☐ 4+ times/week

How would you rate your sleep?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Stress level (0-10)

## Acknowledgement

I understand that Full Body Red Light Therapy is a wellness-based service and not a medical treatment. I agree to communicate any discomfort, changes in health, or concerns to the office and staff.

Patient/client signature (type full name or sign after printing)

Date

Printed name