TheraLight 360 INTAKE FORM

PRIMARY REASON YOU ARE HERE:

- ☐ Chronic Discomfort/Pain
- ☐ New Discomfort/Pain
- ☐ Sports Performance
- ☐ Wellness

IS THIS PROBLEM

- ☐ Less than 5 days old
- ☐ More than 5 days
- ☐ Less than 30 days
- ☐ More than 30 days
- ☐ Getting better
- ☐ Not changing
- ☐ Getting worse

IS YOUR PAIN LOCALIZED OR GENERAL?

- ☐ Localized – small centralized area of pain – I can point right to it
- ☐ Generalized – involves all or most of a body part

HOW OFTEN DOES THE PAIN OCCUR?

- ☐ Changes in severity but always present
- ☐ Intermittent comes and goes constant

INDICATE ALL OF THE FOLLOWING THAT DESCRIBE YOUR PAIN: SELECT ALL THAT APPLY

- ☐ Dull
- ☐ Achey
- ☐ Sharp
- ☐ Shooting
- ☐ Throbbing
- ☐ Squeezing
- ☐ Hot/Burning
- ☐ Stinging or Jabbing
- ☐ Numb
- ☐ Tingling
- ☐ Tender to touch
- ☐ Radiates down arm (Right Left Both)
- ☐ Radiates down leg (Right Left Both)

DOES CONDITION HAVE OR CAUSE

- ☐ Weakness
- ☐ Cramping
- ☐ Swelling
- ☐ Balance Problems
- ☐ Not Applicable

DO YOU USE THE FOLLOWING PHYSICAL AIDS FOR ANY CONDITION?

CANE

- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

CRUTCHES

- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

WALKER

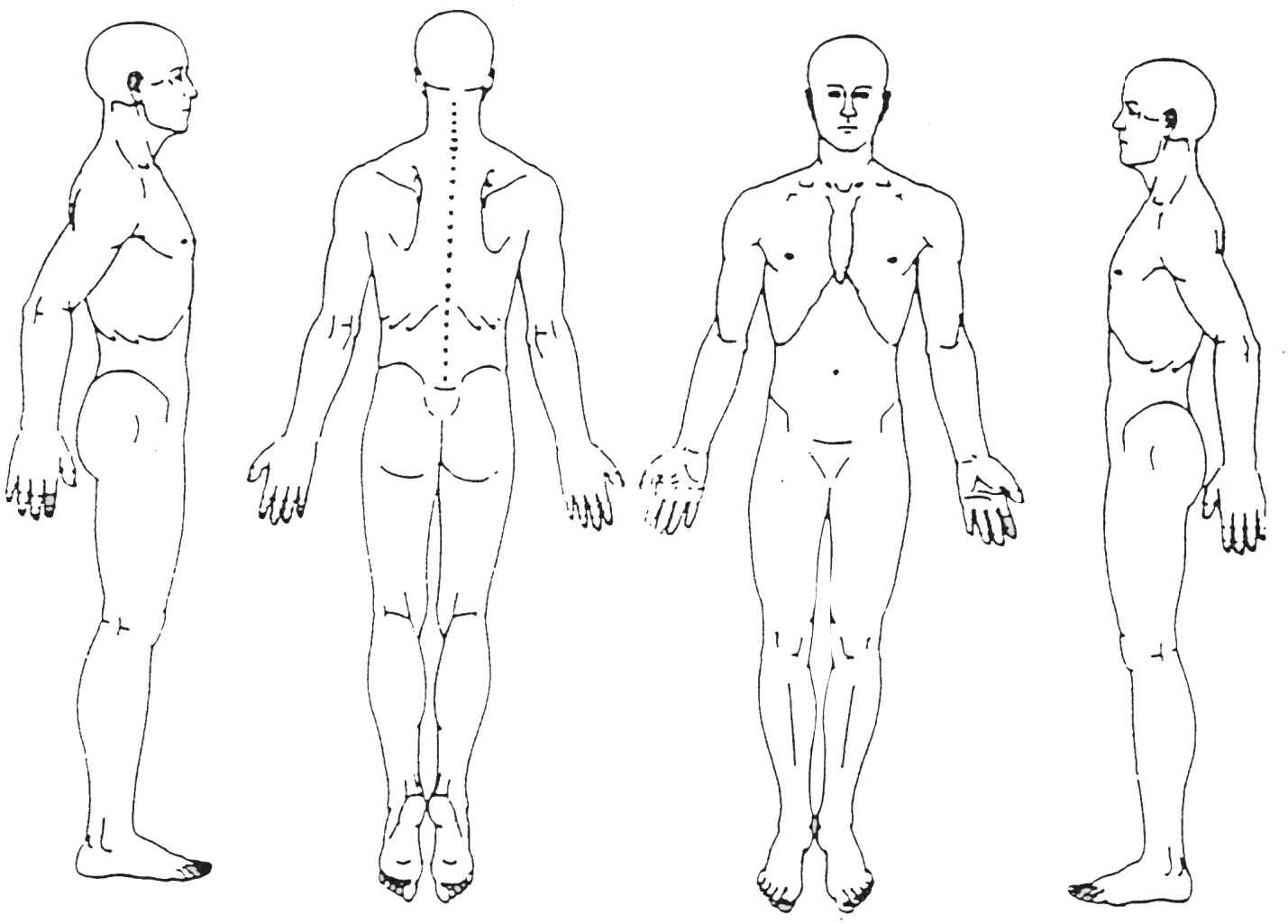
- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

WHEELCHAIR/ SCOOTER

- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

LOCATION OF PAIN

Circle the EXACT area where pain/discomfort is located **RIGHT NOW**. Please be very specific and do not circle entire body part.



TESTS YOU HAVE HAD FOR THIS CONDITION WITHIN THE LAST YEAR

- ☐ X-Ray
- ☐ MRI
- ☐ Neither
- ☐ Both
- ☐ OTHER_____

EVALUATION OF CONDITION BY A HEALTH PROFESSIONAL

Tell us what specialists you have consulted for your current pain problems AND HOW LONG AGO:
Put NA not applicable if you have not seen a health professional for this condition.

- ☐ MD – Medical Doctor _____
- ☐ DO – Doctor of Osteopathy _____
- ☐ N – Nurse Practitioner _____
- ☐ PA – Physician Assistant _____
- ☐ DC – Doctor of Chiropractic _____
- ☐ ND – Naturopathic Doctor _____
- ☐ LAc – Licensed Acupuncturist _____
- ☐ LMT – Licensed Massage Therapist _____
- ☐ PT – Physical Therapist _____

CHOOSE THE LINE THAT BEST DESCRIBES THE PAIN YOU FEEL RIGHT NOW

SELECT ONLY ONE PER ROW

AT REST

- ☐ **ABSENT**
- ☐ **VERY MILD** – Very light barely noticeable pain
- ☐ **UNCOMFORTABLE** – Minor pain - irritating
- ☐ **TOLERABLE** – Moderate pain, however you have adapted to it
- ☐ **DISTRESSING** – Strong, deep pain, like an average toothache
- ☐ **VERY DISTRESSING** – Notice the pain all the time
- ☐ **INTENSE** – Dominates your senses some of the time
- ☐ **VERY INTENSE** – Dominates your senses at least half of the time
- ☐ **HORRIBLE** – Pain so intense you can no longer think clearly at all
- ☐ **UNBEARABLE** – Pain so intense you demand pain killers or surgery no matter the risk
- ☐ **UNIMAGINABLE** – Pain so intense you will go unconscious shortly

WITH MOTION

- ☐ **ABSENT**
- ☐ **VERY MILD** – Very light barely noticeable pain
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CHECK THE BOX(ES) THAT CORRESPONDS TO THINGS THAT MAKE YOUR PAIN WORSE (SELECT ALL THAT APPLY)

- ☐ Looking upward
- ☐ Looking downward
- ☐ Stretching Exercises
- ☐ Standing
- ☐ Bending Over
- ☐ Flexion - Bending motion that decreases the angel of the joint
- ☐ Extension - Straightening motion that increases the angle of the joint
- ☐ Abduction - Motion of body part away from the body
- ☐ Adduction - Motion of body part toward the body
- ☐ Pulling
- ☐ Pushing
- ☐ Pronation – Twisting Left
- ☐ Rotation– Twisting Right
- ☐ Lifting an object
- ☐ Lying on Right Side
- ☐ Lying on Left Side
- ☐ Getting up from sitting down
- ☐ Getting up from lying down
- ☐ Sitting down into a chair
- ☐ Sitting for short periods
- ☐ Sitting for long periods
- ☐ Walking for short distances
- ☐ Walking for long distances
- ☐ Athletic Exercise – comment below
- ☐ Driving for long distances
- ☐ Computer Use
- ☐ Repetitive motions (be specific in comment box)
- ☐ Almost any movement

CHECK THE BOX(ES) THAT CORRESPONDS TO THE THINGS THAT MAKE YOUR PAIN BETTER (SELECT ALL THAT APPLY)

- ☐ Nothing
- ☐ Physical Therapy or Massage
- ☐ Over the counter medications
- ☐ Prescription medications

RANGE OF MOTION - SELECT ONLY ONE PER ROW

1. Describe range of motion AT REST in left column
2. Move affected area in natural range of motion.
3. Stop where pain begins to increase - describe ROM on scale listed below

AT REST

☐	0	None	No Joint Movement
☐	1	Poor	Severe Joint Restriction
☐	2	Fair	Moderate Joint Restriction
☐	3	Good	Mild Joint Restriction
☐	4	Normal	No Joint Restriction

WITH MOTION

☐	0	None	No Joint Movement
☐	1	Poor	Severe Joint Restriction
☐	2	Fair	Moderate Joint Restriction
☐	3	Good	Mild Joint Restriction
☐	4	Normal	No Joint Restriction

PLEASE LIST ALL PAIN MEDICATIONS THAT YOU ARE CURRENTLY TAKING FOR THIS COMPLAINT INCLUDE NAME, DOSE AND HOW OFTEN

_____

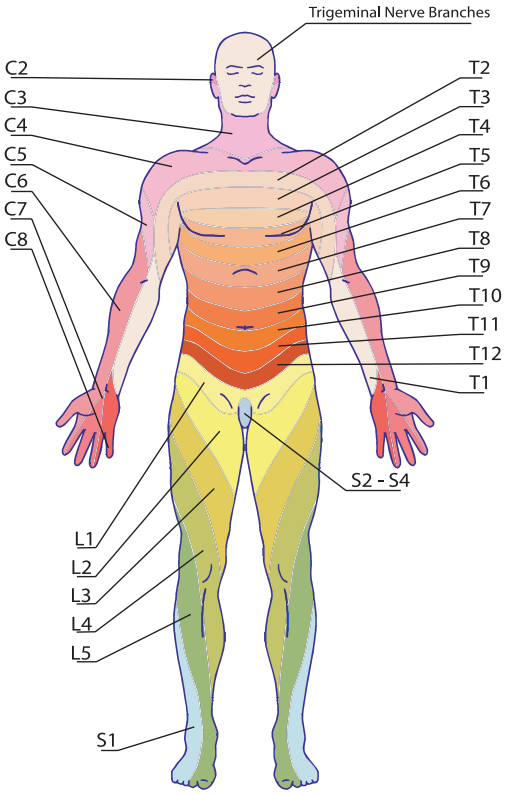
_____

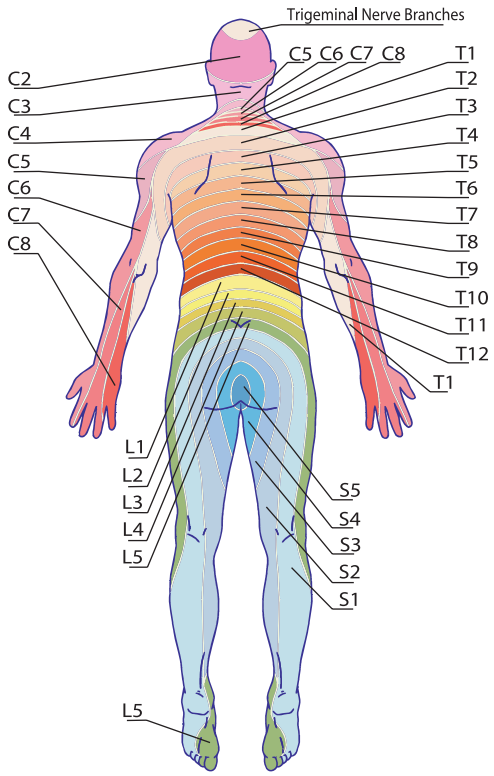
_____

_____

_____

DERMATOME: AN AREA OF THE BODY SUPPLIED BY NERVES FROM A SINGLE SPINAL ROOT





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