

healthlight•

[STRICTLY PERSONAL AND CONFIDENTIAL]

Questionnaire for biophoton therapy – **please complete the form and bring it with you to your first appointment!**

Family name : _____ M / F
First name : _____
Date of birth : _____
Street name and number : _____
Town and postal code : _____
Telephone : _____
e-mail address : _____

To get an idea of the state of your health, we would appreciate it if you would fill in this questionnaire. The information will be used to help us draw up and evaluate your treatment programme and will not be passed on to third parties without your permission.

IMPORTANT:

People who have had an organ transplant and people with synthetic tubes, shunts, plastic blood vessels, or porcine valves in their hearts can NOT be treated.

Questionnaire (*please circle the correct answer)

- PART 1

Medical diagnosis and main problems (physical and mental) _____

When did these problems start? _____

When are these problems at their worst? (for example time, season or after certain activity etc.) _____

Have you ever had an operation?

YES/NO*

If so, for what? _____

Do you have scars from accidents and/or injuries?

YES/NO *

If so, what and where? _____

Have you received implants?

YES/NO *

If so, what kind? _____

Whiplash. Have you ever experienced a whiplash to your head?

YES/NO *

Have you ever had concussion?

YES/NO *

If so, how? _____

What major illnesses/ disorders have you had in the past? _____

What is (or was) your job? _____

• PART 2

LIST OF COMPLAINTS

Please answer all the questions listed below, with respect to the past MONTH.

The numbers range from 1 to 5:

1 = almost never; 2 = rarely; 3 = sometimes; 4 = often; 5 = almost always

Please circle 1 option only

- | | | | | | |
|---------------------------------------|---|---|---|---|---|
| 1. I suffer from insomnia | 1 | 2 | 3 | 4 | 5 |
| 2. I suffer from palpitations | 1 | 2 | 3 | 4 | 5 |
| 3. I am irritable | 1 | 2 | 3 | 4 | 5 |
| 4. I feel restless, tense | 1 | 2 | 3 | 4 | 5 |
| 5. I sweat a lot, for no real reason | 1 | 2 | 3 | 4 | 5 |
| 6. I feel tired | 1 | 2 | 3 | 4 | 5 |
| 7. I'm losing weight, getting thinner | 1 | 2 | 3 | 4 | 5 |
| 8. I have diarrhoea | 1 | 2 | 3 | 4 | 5 |

9. I'm constipated	1	2	3	4	5
10. I'm short of breath even without exertion	1	2	3	4	5
11. I have chest pains	1	2	3	4	5
12. I have a tight feeling in my neck	1	2	3	4	5
13. I have problems swallowing	1	2	3	4	5
14. I have attacks of breathlessness	1	2	3	4	5
15. I yawn a lot	1	2	3	4	5
16. I suffer from a chronic cough	1	2	3	4	5
17. I suffer from dizzy spells	1	2	3	4	5
18. I have problems concentrating	1	2	3	4	5
19. I feel weak (weak muscles)	1	2	3	4	5
20. I suffer from loss of balance	1	2	3	4	5
21. I have problems with my sight	1	2	3	4	5
22. I have memory loss	1	2	3	4	5
23. I need an extreme amount of sleep	1	2	3	4	5
24. I dream a lot	1	2	3	4	5
25. I feel apathetic (depressed)	1	2	3	4	5
26. I have crying fits (or feel like crying)	1	2	3	4	5
27. I suffer from anxiety	1	2	3	4	5
28. I worry a lot	1	2	3	4	5
29. I brood	1	2	3	4	5
30. I don't experience sexual arousal any more	1	2	3	4	5
31. Some foods don't agree with me	1	2	3	4	5
32. I often feel nauseous	1	2	3	4	5
33. I suffer from heartburn	1	2	3	4	5
34. My stomach feels bloated	1	2	3	4	5
35. I have headaches/facial neuralgia	1	2	3	4	5
36. I suffer from stomach/abdominal pains	1	2	3	4	5
37. I suffer from backache/pain in the crotch	1	2	3	4	5
38. I suffer from an aching neck and/or shoulder	1	2	3	4	5
39. My joints bother me	1	2	3	4	5
40. My legs feel heavy	1	2	3	4	5
41. I have restless legs	1	2	3	4	5
42. I have cold hands and/or feet	1	2	3	4	5
43. I'm putting on weight/I'm getting heavier and heavier	1	2	3	4	5
44. I feel extremely thirsty (e.g. I need to drink a lot of water at night)	1	2	3	4	5
45. I have swollen feet/hands	1	2	3	4	5
46. I have problems passing urine	1	2	3	4	5
47. I have menstrual problems (e.g. pain, excessive bleeding)	1	2	3	4	5

48. I have too much work/work pressure	1	2	3	4	5
49. I feel I'm paid too little for the work I do	1	2	3	4	5
50. I don't look forward to going to work	1	2	3	4	5
52. I'm inclined to report sick for work	1	2	3	4	5
53. My work gives me no satisfaction or energy	1	2	3	4	5
53. Stress and tension are not subjects for discussion	1	2	3	4	5
54. I take the following medication:					

name of medication	amount in mg.	per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

When answering questions 55-57, please give a daily average of what you consume in a week:

55. I drink per day	_____	cups of coffee
56. I smoke per day	_____	cigarettes/cigars*
57. I drink per day	_____	glasses of alcohol
58. I assess my health problems as follows		1 2 3 4 5 6 7 8 9 (1 = I feel healthy; 9 = my complaints are insupportable)

• PART 3

MEDICAL QUESTIONS (*please circle the correct answer)

Do you have a heart condition or heart problems?	YES/NO *
Do you have high blood pressure (hypertension)?	YES/NO *
Do you have respiration and/or pulmonary problems?	YES/NO *
Are you currently having treatment from a doctor/specialist?	YES/NO *
Do you have physical problems that are aggravated by sports?	YES/NO *
Do you have bone, muscle or joint disorders?	YES/NO *
Do you currently have a sport injury or have you ever had one?	YES/NO *
Have you been ill in the past month?	YES/NO *
Do you have any remarks that might be useful for the treatment? If so, please note them here: _____	YES/NO *

Thank you for completing this questionnaire!

signature

date