Harmonic Light Therapy Questionnaire

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No 1. Are you currently pregnant?

Yes No 2. Are you taking photosensitive medicines where you have been guided to stay out of the sun by your doctor? If yes, consult your doctor prior to use.

Yes No 3. Are you epileptic?

Yes No 4. Are you sensitive to light?

Yes No 5. Are you currently being treated for an active cancer?

My top areas of concern for myself and my family:

Stress\_\_\_\_ Pain\_\_\_\_ Inflammation\_\_\_\_ Inch Loss\_\_\_\_ Anti-Aging\_\_\_\_ Energy\_\_\_\_\_

Mood\_\_\_\_ Skin\_\_\_\_ Circulation\_\_\_\_\_ Muscle Health\_\_\_\_ Endurance\_\_\_\_ Bones\_\_\_\_\_

Nerves\_\_\_\_ Immunity\_\_\_\_ Joint Health\_\_\_\_ Wound Health\_\_\_\_ Mental Focus\_\_ Sleep\_\_\_\_\_

Digestion\_\_\_\_ Parasites\_\_\_\_\_ Detoxification\_\_\_\_ Memory\_\_\_\_\_ Metabolism\_\_\_ Recovery\_\_\_\_