Lecture IV – Notes

Description: When considering light therapy, the initial step is crucial. It involves assessing the specific needs of the individual and treating any symptoms requiring immediate attention. Selecting the correct colour can greatly influence the effectiveness of the treatment, as well as understanding the colour's connection to the root cause. Additionally, recommending a healing kit with products to support self-treatment exercises will assist the client in continuing their wellness journey.

Following are a few handouts that will be utilized in various assignments. These handouts were designed for you to incorporate into your light therapy sessions, tailored to your specific treatment approach.

Please take notes on the video and class materials either in the space below or in a separate notebook. This will help you to prepare any feedback and questions that you may have as you progress through your studies.

NOTES, COMMENTS & QUESTIONS: ______________________________

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Assignment 2 - Part One
ANALYSING ENERGY USING A PENDULUM

In this exercise, you will be evaluating your own energy levels using a pendulum. There are a few approaches you can take for this assessment. The first method involves holding the pendulum in front of each energy centres and inquiring whether a specific chakra requires more of its corresponding colour. Alternatively, you can use tools such as Colour Energy's Pendulum chart. Hold the pendulum above the chakra names and look for a response to identify where additional support is needed for an energy centre. You can also use this handout and ask the pendulum for help with each question.

Observe how the pendulum reacts to the questions listed below and include any other relevant details to pinpoint why light therapy may be necessary in areas of imbalance.

Definition of pendulum: Pendulum is a term used to describe the fluctuation of a situation between two opposites. It can be utilized to identify the presence of energy flow or disharmony within an energy centre or a specific body part. The movement of a pendulum can be influenced by the electrical currents present in our bodies, and is similar to how a lie detector functions.

1. Does your Crown Chakra require violet light therapy? ❑ Yes, ❑ No, ❑ Not sure

   Could the need for energy in this chakra be attributed to one or more of the following reasons?

   ❑ Mental, ❑ Emotional, ❑ Physical, ❑ Spiritual

   According to the previous response, can you identify any potential reasons that may suggest a connection? Please list any factors that you can think of that may be affecting this chakra:

   ____

   ____

2. Does your Brow Chakra require indigo light therapy? ❑ Yes, ❑ No, ❑ Not sure

   Could the need for energy in this chakra be attributed to one or more of the following reasons?

   ❑ Mental, ❑ Emotional, ❑ Physical, ❑ Spiritual

   According to the previous response, can you identify any potential reasons that may suggest a connection? Please list any factors that you can think of that may be affecting this chakra:

   ____

   ____

3. Does my Throat Chakra require blue light therapy? ❑ Yes, ❑ No, ❑ Not sure

   Could the need for energy in this chakra be attributed to one or more of the following reasons?

   ❑ Mental, ❑ Emotional, ❑ Physical, ❑ Spiritual

   According to the previous response, can you identify any potential reasons that may suggest a connection? Please list any factors that you can think of that may be affecting this chakra:

   ____

   ____

Assignment 2 - Part Two
Analysing Energy Using A Pendulum - Cont'd

4. Does my Heart Chakra require green light therapy? ❑ Yes, ❑ No, ❑ Not sure

   Could the need for energy in this chakra be attributed to one or more of the following reasons?

   ❑ Mental, ❑ Emotional, ❑ Physical, ❑ Spiritual

   According to the previous response, can you identify any potential reasons that may suggest a connection? Please list any factors that you can think of that may be affecting this chakra:

   ____

   ____

5. Does my Solar Plexus Chakra require yellow light therapy? ❑ Yes, ❑ No, ❑ Not sure

   Could the need for energy in this chakra be attributed to one or more of the following reasons?

   ❑ Mental, ❑ Emotional, ❑ Physical, ❑ Spiritual

   According to the previous response, can you identify any potential reasons that may suggest a connection? Please list any factors that you can think of that may be affecting this chakra:

   ____

   ____

6. Does my Sacral Chakra require orange light therapy? ❑ Yes, ❑ No, ❑ Not sure

   Could the need for energy in this chakra be attributed to one or more of the following reasons?

   ❑ Mental, ❑ Emotional, ❑ Physical, ❑ Spiritual

   According to the previous response, can you identify any potential reasons that may suggest a connection? Please list any factors that you can think of that may be affecting this chakra:

   ____

   ____

7. Does my Root Chakra require red light therapy? ❑ Yes, ❑ No, ❑ Not sure

   Could the need for energy in this chakra be attributed to one or more of the following reasons?

   ❑ Mental, ❑ Emotional, ❑ Physical, ❑ Spiritual

   According to the previous response, can you identify any potential reasons that may suggest a connection? Please list any factors that you can think of that may be affecting this chakra:

   ____

   ____

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Basic Essentials – Reference Chart

Please refer to the list below to help you analyse a Client Intake Form.

- ❑ **FOOD: What You Eat (Question: Is your diet mainly alkaline?)**
  - ❍ Alkaline/Acid Balance
  - ❍ 7-10 Servings of Fruits & Vegetables
  - ❍ 2-3 Meat/Alternative Servings
  - ❍ 2-3 Milk/Alternative Servings
  - ❍ 6-8 Grain Servings
  - ❍ 30-40mls Unsaturated Oils & Fats
  - ❍ Additional Nutritional Supplementation

- ❑ **FLUIDS: What You Drink (Question: Do you drink enough water daily?)**
  - ❍ 8 Glasses of Alkaline Water
  - ❍ Herbal Tea

- ❑ **EXERCISE: Your Physical Activity (Question: Are you exercising your body suffiently?)**
  - ❍ 10,000 Steps a day
  - ❍ 30 Minutes Physical Activity, 3 Times Weekly

- ❑ **SLEEP: How You Rest (Question: Is your body able to repair itself while you sleep?)**
  - ❍ 8 Hours sleep
  - ❍ Mindful rest during the day (breaks)

- ❑ **AIR: How and What You Breathe (Question: Are you breathing clean air?)**
  - ❍ Deep Breathing
  - ❍ Purified/Ionized air

- ❑ **SUNLIGHT: Light Quality (Question: Are you getting enough Vitamin D?)**
  - ❍ 2-4 Hours of natural light daily

- ❑ **Various Therapy Treatments (Question: How do your support yourself?)**
  - ❍ Biopulsar Full Holistic Scan (Fitness Report)
  - ❍ Crystal Light Therapy | ❍ Gemstone Therapy
  - ❍ Nutrition Therapy | ❍ Herbal Consultations
  - ❍ Herbs & Tinctures | ❍ TCM | ❍ Homeopathy
  - ❍ Aromatherapy for Endocrine Glands & Organ Support
  - ❍ Massage | ❍ Lymph Drainage | ❍ Energywork

- ❑ **Other:** ____

____

____

Assignment 3 - Part One
Analysis of New Client Intake Form

This task requires you to fill out a New Client Intake Form for yourself initially, and then for several practicum treatments. The form will help you identify patterns and confirm any suspected results.

After completing your Intake form, you will analyse each section to create a portfolio of yourself first. Later, for your practicums and offering longer holistic sessions, this form will be very useful.

Intake Analysis Part 1

1. What did your client indicate with what they checked off as the statement that best represents their purpose in seeking alternative health care. As you review the client's complete Intake Form, can you understand their response to this question? ___Yes, ___No

How can you verify their opinion of their health condition? ______________________________

____

2. What did the client list as their Top 3 Health Goals? From their Intake Form note anything that would help them to accompish their goal. This may lead into the next question.

____

____

____

3. What did the client list as their top three health concerns? Did you notice anything from their Intake Form that could aggravate their condition? Please list below what you noted.

____

____

____

4. Was there any connection between their family medical history that shows up in their answers on their Intake Form?

____

____

5. Was there any connection between their personal medical history that shows up in their answer on their Intake Form?

____

____

6. Was there any connection between their lifestyle choices that compounds their condition or interfers with them accomplishing their goal.

____

____

Assignment 3 - Part Two
Analysis of New Client Intake Form - Cont'd

Intake Analysis Part 2

On this page you can note how well a person takes care of their basic needs. Essentials of life can greatly influence your body's automatic repair system. Below highlight areas that may assist the client in making improvements.

____

____

____

Intake Analysis Part 3-5

In part 3-5 of the Intake Form, count how many checkmarks are in each colour section. this may help you to understand the connection between where they have the most symptoms in comparison to their weakest energy centre (chakra). Note what you see in each section.

7. Indigo/Violet: Number of checks: ___ and any assocition to the above. ________________________

____

____

8. Blue: Number of checks: ___ and any assocition to the above. ________________________

____

____

9. Green: Number of checks: ___ and any assocition to the above. ________________________

____

____

10. Yellow: Number of checks: ___ and any assocition to the above. ________________________

____

____

11. Orange: Number of checks: ___ and any assocition to the above. ________________________

____

____

12, Red: Number of checks: ___ and any assocition to the above. ________________________

____

____

Intake Analysis Part 5

In part 5, near the bottom of the page, there are additional questions that give additional information on one's stress factors. Note any areas that have been checked in the number 1 and 2 zones. These are the areas that need to be addressed during a longer holistic consultation. If a client is not feeling supported, then you know to help them work on their red energy to strengthen their connection to inner confidence as well it is hugely connected to one's physical health. For overall enjoyment of life, this is connected to one's orange energy centre.

13. What can you recommend to help in supporting the client for each question asked below?

Health & Well Being: ______________________________

____

____

Energy Level: ______________________________

____

____

Support of Family & Friends: ______________________________

____

____

Support of Employer & Coworkers: ______________________________

____

____

Handling of Stress: ______________________________

____

____

Overall Enjoyment of Life: ______________________________

____

____

New Client Intake Form - Part 1

INSTRUCTIONS:
Please be assured that all your responses will be kept confidential. If you are feeling rushed or preoccupied, we kindly ask you not to proceed with this questionnaire. Your input is vital for your overall health evaluation. If you are unsure about a question or find it unclear, please mark it with a question mark (?). Thank you.

Please check the statement that best represents your purpose in seeking alternative health care:

____ I believe that I am a generally healthy individual seeking guidance to further improve and maintain my well-being. My goal is to enhance my overall health so that I can extend my lifespan and enjoy a higher quality of life.

____ I have noticed certain health issues that are hindering my ability to fully embrace life. I am keen on addressing these concerns to not only increase my longevity but also optimize my well-being.

____ I am experiencing serious health issues that seem to be unmanageable or unresponsive to conventional healthcare methods. My aim is to address these issues and improve my longevity while also elevating my quality of life.

Top 3 Health Goals:
1. ______________________________
2. ______________________________
3. ______________________________

Top 3 Health Concerns/Complaints/Illnesses:
1. ______________________________
2. ______________________________
3. ______________________________

FAMILY MEDICAL HISTORY (check off any family heredity issues):
❍ Diabetes ❍ High or Low Blood Pressure ❍ Heart Trouble ❍ TB ❍ Allergies ❍ Asthma ❍ Epilepsy
❍ Sinus Problems ❍ Ulcers ❍ Eye Disease ❍ Arthritis ❍ Rheumatism ❍ Alcoholism ❍ Drug Addiction
❍ Kidney Disease ❍ Liver Problems ❍ Spinal Problems ❍ Mental Disorders ❍ Other: ____________
❍ Cancer | Describe: ______________________________

PERSONAL MEDICAL HISTORY:
Are you taking any medication? Yes ❍ No ❍ What type and how often? ____________
Have you ever had any surgery? Yes ❍ No ❍ When and what type? ____________
Have you ever been in any accidents? Yes ❍ No ❍ If yes, explain: ____________
Have you had any fractures, torn ligaments, etc.? Where? ____________
Have you ever been seriously ill? Yes ❍ No ❍ If yes, what type? When? ____________
Known food allergies/sensitivities: ____________

LIFESTYLE (check off all that apply to you):
HABITS: ❍ Cigarettes/Cigars | Daily #: ___ ❍ Recreational Drugs | What type & frequency: ____________
❍ Medicine/Pill/Drug Abuse | What type & frequency: ____________ ❍ Other: ____________
TYPICAL DIET: ❍ Beef ❍ Pork ❍ Poultry ❍ Eggs ❍ Fish ❍ Tofu ❍ Beans ❍ Cold cuts ❍ Sausages
❍ Hot Dogs ❍ Cheese ❍ Yogurt ❍ Ice cream ❍ Milk ❍ Soy ❍ Margarine ❍ Butter ❍ Bread
❍ Pasta ❍ Rice ❍ Potatoes ❍ Fried Foods ❍ Cereal ❍ Desserts ❍ Chocolate ❍ Candies ❍ Chips
❍ Fresh Fruits/Vegetables ❍ Frozen Fruits /Vegetables ❍ Canned Fruits/Vegetables ❍ Dried Fruits/Vegetables
❍ Tap Water ❍ Filtered Water ❍ Bottled Water ❍ Salt ❍ Sea Salt ❍ Sugar ❍ Raw Sugar ❍ Honey/Agave
❍ Sweeteners ____ # of packets daily ❍ Other: ____________
❍ Cook with Microwave ❍ Cook with Aluminum ❍ Eat take out or in restaurants ❍ Organic/Health Foods

EXERCISE: ❍ Never ❍ Little ❍ Moderate ❍ Heavy ❍ Type of Exercise: ____________

MISC: ❍ Single ❍ Married ❍ Divorced ❍ Common-law ❍ Widowed ❍ Children #____ | Ages: ________
❍ Stressful home conditions ❍ Trouble sleeping ❍ Trouble relaxing ❍ Unhealthy home (mold, smokers, etc.)
❍ Stressful job ❍ Unhealthy work conditions (factory work, printing, chemicals, etc.) ❍ Relationship problems

New Client Intake Form - Part 2

PLEASE PROVIDE RESPONSES TO THE QUESTIONS BELOW. THE MORE DETAILED YOUR ANSWERS, THE GREATER OUR COMPREHENSION OF YOUR CONCERNS.

1. How much water do you drink daily? ❑ Less than 4 glasses • ❑ 4-6 glasses • ❑ 6-8 glasses • ❑ More than 8 glasses
   What type? ❑ Tap Water • ❑ Bottled Water | Brand/Type (distilled, reverse osmosis, other): ____________________
2. How many cups of coffee, tea or stimulant drinks do you consume daily?
   ❑ Coffee • ❑ Tea• ❑ Pop/Power Drinks | ❑ None • ❑ 1-2 • ❑ 3-4 • ❑ 5 or more
3. What type and how many alcoholic drinks do you enjoy weekly?
   ❑ Beer • ❑ Wine • ❑ Liquor | ❑ None • ❑ 1-2 • ❑ 3-4 • ❑ 5-10 • ❑ More than 10 • ❑ More than 20
4. What blood type are you? ❑ A • ❑ B- • ❑ B+ • ❑ AB- • ❑ AB+ • ❑ O- • ❑ O+ • ❑ Don't recall/Not sure
5. What is your typical breakfast? ____
6. What is your typical lunch? ____
7 What is your typical dinner? ____
8. List typical snacks and desserts: ____
9. What time do you eat in the evening? ❑ Before 6pm • ❑ Between 6-8 • ❑ After 8 | Do you skip meals: ❑ Yes ❑ No
10. How often do you consume nuts, seeds and oily fish? ❑ Daily • ❑ 1-3 Week • ❑ Seldom
11. What type of protein do you eat in a typical day? • ❑ Fish • ❑ Chicken • ❑ Meat • ❑ Beans • ❑ Tofu
    ❑ Eggs • ❑ Nuts • ❑ Ancient Grains • ❑ Protein Shakes • ❑ Other: ______________
12. How often do you eat wheat (bread, pasta, cakes, etc)? ❑ None • ❑ 1-2 portions daily • ❑ 3-4 daily ❑ 5 or more
13. How many servings of fruit do you eat a day? ❑ None • ❑ 1-2 • ❑ 3-4 ❑ 5+ • ❑ Raw • ❑ Canned • ❑ Frozen
    What type? ______________________________ Method: ❑ Raw • ❑ Cooked • ❑ Microwaved
14. How many servings of veggies do you eat a day? ❑ None • ❑ 1-2 • ❑ 3-4 ❑ 5+ • ❑ Raw • ❑ Canned • ❑ Frozen
    What type? ______________________________ Method: ❑ Raw • ❑ Cooked • ❑ Microwaved
15. What supplements do you take and why? ____
    Quality/Brand: ❑ Grocery/Drug Store • ❑ Health Store • ❑ Professional Brand/Practitioner Recommended
16. Describe any digestive problems? ____
    Frequency of Bowel Movement: ___ x Daily or ___ x Weekly • ❑ Constipation • ❑ Diarrhea
    Frequency of Urination: ❑ 1-2 Daily • ❑ Normal • ❑ Too often/Almost as fast I drink, I release
17. Sleep patterns: ❑ Less than 6 hours • ❑ 6-8 hrs • ❑ 8-10 hrs ❑ More than 10 hrs • ❑ Restful • ❑ Restless
    During the day do you get tired? ❑ Never • ❑ Rarely • ❑ Sometimes • ❑ Usually | At what time(s): ______________
18. How many hours are you sitting daily: ❑ Less than 6 hours • ❑ 6-10 hrs • ❑ 10-14 hrs • ❑ More than 14 hrs
19. Hours combined on computer, cell/phone and watching TV: ❑ Less than 6 hours • ❑ 6-10 hrs • ❑ More than 10 hrs
20. Have you ever had the flu shot? ❑ No • ❑ Yes | If yes, frequency & approx. date of last shot: ______________
    Vaccinations: ❑ Measles • ❑ Mumps • ❑ Chicken Pox • ❑ Polio • ❑ Tetanus • ❑ Hepatitis C
    Viruses: ❑ Measles ❑ Mumps ❑ Chicken Pox ❑ Mono • ❑ Cold Sores • ❑ Herpes • ❑ Acne • ❑ Other: ________
21. Deodorant: ❑ Antiperspirant • ❑ Regular Deodorant • ❑ Natural Product • ❑ None
22. Is there anything else that you can think of that may contribute to your current health condition?
    ____
23. How do your relieve your stress: ______________________ | Do you have any hobbies: ______________________
24. What type of practitioners do you visit monthly or regularly? ❑ Family Doctor • ❑ Specialist in: ______________
    ❑ Naturopath • ❑ Chiropractor • ❑ Acupuncturist • ❑ Massage • ❑ Reiki/Energyworker • ❑ Other: ________

New Client Intake Form - Part 3

INSTRUCTIONS:
Please indicate any health conditions you have encountered in the past few months or have experienced recurring symptoms throughout your life. For conditions with multiple symptoms listed (indicated with a colon ":" or separated by a dividing line "|"), please select the options that best match your experience.

HEAD | NEUROLOGICAL

___ ADD/ADHD
___ Addiction
___ Anxiety
___ Autism
___ Autonomic Nervous System Imbalances
___ Bipolar
___ Cloudy or Foggy Thinking
___ Coordination Problems
___ Concentration Difficulties
___ Confusion
___ Depression
___ Dyslexia
___ Equilibrium Imbalances
___ Excessive Daydreaming
___ Excessive Drowsiness
___ Fainting
___ Fears, Paranoia
___ Feeling of Fullness in Head
___ Hair Loss
___ Headaches
___ Learning Difficulties/Disabilities
___ Light-headedness
___ Manic depression
___ Memory Loss: Long Term | Short Term
___ Mental Dullness/Tiredness
___ Mental Illnesses
___ Migraines
___ Mood Swings
___ Nervousness
___ Nightmares | Night Terrors
___ Panic Attacks
___ Pituitary Problems
___ Schizophrenia
___ Seizures
___ Sinus Congestion
___ Sleep: Apnea | Disorders | Problems
Hypersomnia | Hyponia | Insomnia
Narcolepsy | Sleep Talking/Walking
___ Sleepiness After Eating
___ Suicidal Tendencies
___ Tinnitus
___ Tourette Syndrome
___ Other: ___________________________

EYES | VISION

___ Blindness | Loss of Vision
___ Bloodshot Eyes
___ Blurred Vision
___ Cataracts
___ Conjunctivitis (Pink Eye)
___ Darkness Under Eyes
___ Eye Irritations: Itchy | Watery | Inflamed
___ Eye Pain
___ Glaucoma
___ Macular Degeneration
___ Poor Night Vision
___ Puffy Eyes
___ Sensitivity to Light
___ Tired Eyes
___ Vision: Farsightedness | Nearsightedness
___ Wears Sunglasses Daily
___ Other: ___________________________

EARS

___ Dizziness
___ Ear Drainage
___ Earaches/Pain
___ Fluid in Middle Ear
___ Hearing Loss
___ Itching Ear
___ Loss of Balance
___ Over Sensitivity to Sounds
___ Recurrent Ear Infections
___ Ringing in Ears
___ Other: ___________________________

NOSE

___ Excessive Mucous Formation
___ Loss of Smell
___ Nose Bleeds
___ Nose Pain
___ Over Sensitivity to Smells
___ Recurrent Sinusitis/Sinus Problems
___ Runny nose
___ Stuffy nose
___ Other: ___________________________

MOUTH | DENTAL

___ Amalgam (Mercury in Fillings)
___ Bleeding Gums
___ Blisters
___ Bruxism
___ Canker/Cold Sores
___ Dry Mouth | Lips
___ Enamel Disorders
___ Excessive Cavities
___ Gingivitis | Periodontitis
___ Grind Teeth
___ Gum Disease
___ Itchiness on Roof of Mouth
___ Loss of Taste
___ Odour in Mouth Upon Waking
___ Over Sensitivities to Taste
___ Pain in Gums | Mouth
___ Root Canal
___ Soft/Porous Teeth
___ Toothaches
___ TMJ | Tightness in jaw
___ Other: ___________________________

THROAT

___ Chronic Cough
___ Difficulty Swallowing
___ Dryness in Throat
___ Gagging
___ Goitres
___ Hoarse or Sore Throat
___ Laryngitis
___ Lump in Throat
___ Slurred Speech
___ Stuttering
___ Swollen Glands
___ Thyroid Imbalances
___ Tonsillitis
___ Other: ___________________________

NECK

___ Lack of Mobility in Neck Region
___ Neck pain
___ Stiff neck
___ Whiplash
___ Other: ___________________________

ENDOCRINOLOGY

___ Thyroid: Hyper | Hypo
___ Graves' Disease
___ Hashimoto's Disease
___ Goiter
___ Poor: Hair | Nail Growth
___ Other: ___________________________

MISCELLANEOUS BLUE IMBALANCES

___ Atlas Problems | Poor Posture
___ Fever
___ Hyperactivity
___ Inability to: Lose | Gain Weight
___ Melancholy
___ Other: ___________________________

IMMUNOLOGY

___ Auto-Immune Disease
___ Cancer (what type): ________________

New Client Intake Form - Part 4

___ Chronic Fatigue
___ Ear Infections
___ Environmental Allergies
___ Food Allergies
___ Frequent Colds or Flus
___ Inflammation
___ Lymph Problems
___ Sluggish Lymph System
___ Strong Body Odour
___ Upper Respiratory Allergies
___ Use of Antibiotics
___ Yeast Infections
___ Other: ___________________________

ARMS, HANDS & SHOULDERS

___ Hands: Clammy | Cold | Dry | Sweaty
___ Elbow pain
___ Numbness/Stiffness/Soreness in Fingers
___ Prickling Sensation in Hands
___ Shoulder Pain
___ Swollen Fingers
___ Upper Arm Pain
___ Wrist Pain
___ Other: ___________________________

RESPIRATORY

___ Airborne Allergies
___ Asthma
___ Bronchitis
___ Chronic Cough
___ Chronic Infections
___ Chronic Mucus/Phlegm
___ Coughing Blood
___ Difficulties Breathing When Lying Down
___ Emphysema
___ Mold
___ Pain When Breathing
___ Pneumonia
___ Pulmonary Vascular Disease
___ Shortness of Breath
___ Sinus Infections / Polyps
___ Tightness in Chest
___ Other: ___________________________

CARDIOVASCULAR | BREAST

___ Blood Pressure - High
___ Blood Pressure - Low
___ Breast Tenderness
___ Chest Congestion
___ Chest Pain
___ Cholesterol Level - High LDL
___ Cholesterol Level - High Total
___ Cholesterol Level - Low LDL
___ High Triglycerides
___ Cysts in Breast or Lymph Glands
___ Fainting
___ Heartbeat Irregularity
___ Heart Attack
___ Heart Disease
___ Heart Pain
___ Heart Palpitations
___ Heart Rate 85-100 beats per min.
___ Tachycardia - 100+ beats per min.
___ Phlebitis
___ Stroke
___ Varicose Veins
___ Other: ___________________________

MISCELLANEOUS GREEN IMBALANCES

___ Hypertension
___ Joint Aches and Pains
___ Muscle Aches and Pains
___ Muscle Weakness
___ Passivity/Lethargy
___ Other: ___________________________

LIVER | HEPATIC

___ Anemia
___ Chemical Sensitivities
___ Fatty Liver
___ Gallstones
___ Hepatitis: A | B | C (circle one)
___ Liver problems
___ Other: ___________________________

METABOLIC

___ Diabetes: Type I | Type II
___ Hypoglycemia
___ Difficulty Gaining Weight
___ Difficulty Losing Weight
___ Overweight
___ Metabolic Syndrome
___ Other: ___________________________

GASTROINTESTINAL | STOMACH

___ Abdomen Pain or Cramps
___ Acid Reflex/Heartburn
___ Bad Breath
___ Bloating/Bloated Stomach
___ Difficulty Swallowing
___ Candida
___ Colon Polyps
___ Constipation
___ Crohn's Disease
___ Diarrhea
___ Diverticulosis/Divertculitis
___ Excessive belching
___ Flatulence (passing gas)
___ Food Cravings
___ Food Intolerances | Allergies
___ Hemorrhoids
___ Hernia: Inguinal | Hiatus
___ Indigestion
___ Irritable Bowel Syndrome (IBS)
___ Mucus
___ Nausea
___ Parasites
___ Poor Appetite
___ Rectal Pain
___ Stomach Fullness Long After Eating
___ Stools: Runny | Hard | Normal | Blood
Yellow | Red | Black
___ Ulcerative Colitis
___ Ulcers
___ Vomiting
___ Other: ___________________________

MISCELLANEOUS YELLOW IMBALANCES

___ Colitis
___ Herpes
___ High Toxin Levels
___ Nervousness
___ Parasites
___ Poor Work Habits
___ Ringworm
___ Salt Cravings: Salt | Sweet
___ Other: ___________________________

URINARY | RENAL

___ Bladder: Infections | Cystitis
___ Blood in Urine
___ Difficulties Urinating
___ Discolouration in Urine
___ Frequent Urination
___ Inability to Hold Urine
___ Infrequent Urination
___ Gout
___ Kidney Stones
___ Painful Urination
___ Strong Odour in Urine
___ Swelling of the Hands, Feet or Ankles
___ Water retention

SKIN | DERMATOLOGY

___ Acne
___ Bruise Easily | Tender areas
___ Change is Skin Texture
___ Dandruff
___ Eczema | Dermatitis
___ Excessive: Dry | Oily Skin
___ Hives
___ Itchy Skin
___ Liver Spots
___ New Moles
___ Pallor
___ Pimples: Lower (chin) | Mid (nose/cheeks)
Upper Face (forehead) | Neck | Head
___ Poor Healing of Cuts/Sores/Wounds
___ Psoriasis
___ Rashes
___ Rosacea
___ Sensitive to Touch
___ Sores
___ Thinning: Skin | Skin Tags
___ Varicose Veins
___ Other: ___________________________

New Client Intake Form - Part 5

REPRODUCTIVE ORGANS
WOMEN ONLY:

___ Bloating
___ Frequent Yeast Infections
___ Frigidity
___ Hot Flashes/Night Sweats
___ Hysterectomy
___ Menopause
___ Menstrual Cramps/Pain
___ Nursing
___ Painful Intercourse
___ Periods: None | Irregular | Painful | Heavy
Blood Clots
___ Periomenopause
___ Polycistic Ovaries
___ PMS/Mood Swings
___ Pregnant
___ Problems Conceiving
___ Vaginal Yeast Infections
___ Vaginal Itching
___ Vaginal Discharge
___ Other: ___________________________

FOR BOTH SEXES:

___ Bladder Issues
___ Burning Urination
___ Frequent Urination
___ Loss of Libido
___ Urinary Tract Infections
___ Other: ___________________________

MEN ONLY:

___ Erectile/Impotency Dysfunction
___ Infertility
___ Prostate Enlargement
___ Urinary Difficulties: Slow | Dribbling
___ Vasectomy
___ Other: ___________________________

SEXUAL HEALTH

___ Herpes Simplex II (Genital)
___ HIV
___ STD's
___ Other: ___________________________

MISCELLANEOUS ORANGE IMBALANCES

___ Alcohol Abuse
___ Allergies
___ Bacterial problems
___ Dizziness
___ Drug Abuse
___ Eating disorders (Binge or Spree Eating)
___ Emotional Instability
___ Excessive Hunger
___ Hard Stools
___ Hypersensitive to Environment
___ Muscle Cramps | Spasms
___ Night Sweats
___ Other: ___________________________

MUSCLE, BONE & JOINT

___ Arthritis: Osteo | Rheumatoid
___ Chronic Pain: Muscles | Joints
___ Osteoporosis or Osteopaenia
___ Other: ___________________________

BACK

___ Pain between shoulder blades
___ Lower back pain
___ Muscle spasms in back
___ Spinal meningitis
___ Other: ___________________________

LEGS & FEET

___ Ankle | Knee Problems
___ Cold Feet
___ Numbness in Legs | Feet
___ Pain in Buttocks
___ Pain in Feet
___ Pain in Hip Joints
___ Restless Leg Syndrome
___ Swollen Ankles or Feet
___ Varicose Veins
___ Circulation Problems

MISCELLANEOUS RED IMBALANCES

___ Aggressive Behaviour
___ Anemia
___ Bladder Infections
___ Brittle Bones
___ Chronic Fatigue
___ Constipation
___ Depression
___ Difficulties Waking Up
___ Feeling Rundown
___ Frequent Colds
___ Heaviness: Mentally | Physically
___ Hemorrhoids/Piles
___ Hyperactivity
___ Irritability
___ Lack of Sex Drive
___ Obesity
___ Restlessness
___ Rheumatism | Arthritis
___ Sciatica
___ Tired For No Reason
___ Other: ___________________________

CONDITIONS

___ Aids
___ Blood Disorders
___ Hemophilia
___ Other Contagious Disease
___ Multiple Sclerosis
___ Other: ___________________________

Circle appropriate number: 1 = Poor | 2 = Below Average | 3 = Average | 4 = Very Good | 5= Excellent

Overall state of Health & Well Being: 1 - 2 - 3 - 4 - 5
Daily Energy Level: 1 - 2 - 3 - 4 - 5
Support of Family & Friends: 1 - 2 - 3 - 4 - 5
Support of Employer & Coworkers: 1 - 2 - 3 - 4 - 5
Handling of Stress: 1 - 2 - 3 - 4 - 5
Overall Enjoyment of Life: 1 - 2 - 3 - 4 - 5

I understand that a ChromaLight Practitioner does not have the authority to prescribe, treat, or diagnose any specific medical condition. I, the undersigned, am freely choosing to undergo a Light Therapy Treatment. Any discussions regarding general health conditions are considered my own personal opinion, and I acknowledge the importance of following my doctor's advice as recommended by the ChromaLight Therapist.

Name: ___________________________ Date: ______________

Signature: ___________________________ Birthdate: ____ / ____ / ____ Height: ____________
Month Date Year

Email: ___________________________ Occupation: ____________________ Weight: ________