Firefly Light Therapy Evaluation

12506 18th St. NE,
Lake Stevens, WA 98258
Tel: 360 • 913 • 0682

CLIENT INFORMATION

Name: _____

Address: _____ City: _____

Zip: _____ Home/Cell Phone: _____

Email Address: _____

Birthdate: _____ Age: _____ Gender: ☐ Male ☐ Female

Pronoun: _____

Occupation: _____ Employer: _____

How were you referred to Firefly Light Therapy Treatment? :

☐ Family Member ☐ Friend ☐ Doctor: _____

☐ Other: _____

In event of an Emergency

Name: _____ Relationship to Client: _____

Home Phone #: _____ Cell#: _____ Work#: _____

Informed Consent For Firefly Therapy

Firefly therapy utilizes packets of light called Photons to stimulate blood circulation to the treatment area. This results in relief of pain and reduction of symptoms associated with soft tissue injury, such as swelling. Firefly therapy also decreases the healing time associated with superficial injuries, such as burns, cuts, and contusions.

Adverse effects from Firefly therapy are normally rare and temporary. These effects may include from multiple sources, in most cases involving hypersensitivity to light, preexisting medical conditions, thermal effects, excessive pressure from the treatment unit, and overstimulation. **Firefly therapy can cause serious damage to the eye; therefore, it is very important to wear protective glasses that will be provided at all times during treatment.**

Although Rare, the most common adverse effects to Firefly therapy are:

1.) Temporary increase in pain during Firefly application

2.) Temporary increase in pain in the day or days following Firefly therapy

3.) Mild bruising from stimulation of blood circulation or direct pressure of treatment unit

4.) Temporary dizziness

5.) Reactions when photosensitizing drugs are used with Firefly Therapy

I have read and understand the risks of Firefly therapy. I agree to wear the protective glasses provided to me at all times during my treatment

Patient Signature: _____ Date: _____

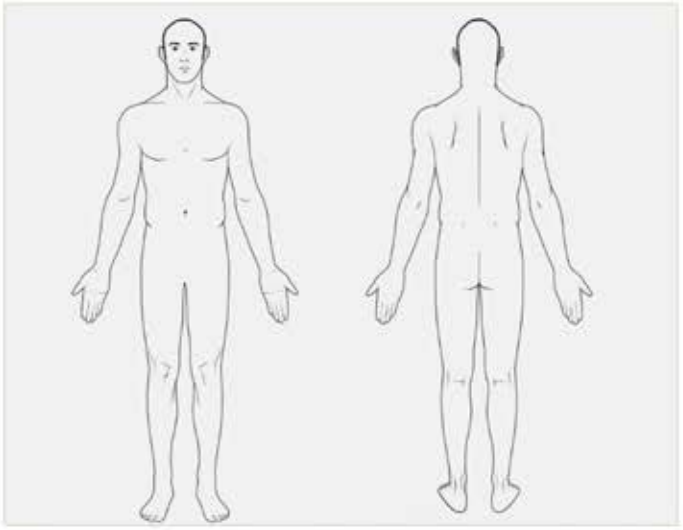
Briefly describe your current symptoms? _____

_____

When did your symptoms start? _____

_____

Please mark the location where you have the pain or other symptoms.



Please describe your symptom(s).

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting

☐ Burning ☐ Tingling ☐ Other _____

Since your symptom(s) began, are they …

☐ Increasing ☐ Decreasing ☐ Not changing

How often do you experience your symptom (s)?

☐ Constantly (76% - 100%) ☐ Frequently (51% - 75%)

☐ Occasionally (26% - 50%) ☐ Intermittently (0% – 25%)

If anything, what makes this better? _____

_____

If anything, what makes this worse?_____

_____

None Unbearable

Rate the severity of your pain in the last 24 hours

0 1 2 3 4 5 6 7 8 9 10

0 1 2 3 4 5 6 7 8 9 10

How much have your symptoms interfered with your usual daily activities? (outside the home & housework)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

In general, would you say your overall health right now is …

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please list any other health care providers consulted for this condition.

_____

Women: Are you or is there a possibility that you may be pregnant? _____

If yes, what is your due date? _____

For Office use only:

DX Codes: _____ _____ _____ _____

Indicate if an *immediate* family member has / had any of the following:

___ Rheumatoid Arthritis ___ Heart Problems ___ Diabetes ___ Lupus ___ Stroke ___ Other _____

Please indicate if you have had or presently have any of the following conditions:

Cardiovascular

___ Fainting ___ Heart Disease ___ High/Low Blood Pressure ___ Irregular Heartbeat ___Phlebitis
___ Poor Circulation ___ Swelling of Hands/Feet ___Swelling of Legs ___Other: _____

Ear/Nose/Throat

___ Dizziness ___ Hearing Loss ___Sinus Infection ___ Nose Bleed ___ Sore Throat
___ Jaw Clicks ___ Bleeding Gums ___ Difficulty Swallowing ___ Other _____

Gastrointestinal

___ Nausea/Vomiting ___ Liver Problems ___ Constipation ___ Diarrhea ___ Ulcers
___ Black /Bloody Stools ___ Gallbladder Problems ___ Bowel Problems ___ Other _____

Musculoskeletal

___ Osteoporosis ___ Arthritis ___ Joint Stiffness ___ Muscle Weakness ___ Gout
___ Broken Bones ___ Joints Replaced ___ Other_____

Respiratory

___ Asthma ___ Bronchitis ___ Cold/Flu ___ Cough/Wheezing ___ Emphysema
___ Difficulty Breathing ___ Pneumonia ___ Shortness of Breath ___ Other _____

Eyes

___ Glaucoma ___ Double Vision ___ Blurred Vision ___ Color Blindness ___ Cataracts
___ Glasses ___ Eye Pain ___ Poor Vision ___ Other _____

Genitourinary

___ Kidney Disease ___ Burning Urination ___ Frequent Urination ___ Blood in Urine
___ Kidney Stone ___ Lower Side Pain ___ Other _____

Neurological

___ Stroke ___ Seizure ___ Severe Headaches ___ Numbness ___ Head Injury
___ Pinched Nerve ___ Carpal Tunnel ___ Brain Aneurysm ___ Other _____

Hematologic/Lymphatic

___ Hepatitis ___ Blood Clots ___ Easy Bleeding ___ Easy Bruising ___ Cancer
___ Fever ___ Chills ___ Sweats ___ Other _____

Endocrine/Constitutional

___ Diabetes ___ Thyroid Disorder ___ Menstrual Problems ___ Other _____
___ Weight Gain ___ Weight Loss ___ Difficulty Sleeping ___ Other _____

Surgeries/ Hospitalizations: _____

Serious Illness or Injury: _____

Allergies: _____

Medications taken within the last two months (include over the counter and vitamins): _____

_____

Habits: Caffeine (use/day) _____ Alcohol _____ Drugs (type/use/week) _____

Tobacco: Current Smoker (use/week): _____ Former Smoker, quit date: _____ Never Smoked _____

Are there any other issues concerning your health that you would like the doctor to be aware of? _____

_____

Have you had any other significant traumas? (Auto Accidents, falls, etc.): _____

_____

HIPPA PRIVACY AUTHORIZATION FORM

**** AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION****

I authorize Kristen Sandquist at Wolfpack Wellness Den to keep record and disclose my health information in necessary circumstances. Necessary circumstances would include:

- Disclosing your health information to another trusted healthcare provider in regards to verifying treatment and/or x-rays.
- Disclosing your healthcare information to another trusted healthcare provider in regards to referrals for continuing treatment.
- Disclosing your healthcare information and billing records to a trusted party if they become responsible of payment we can't obtain.
- Disclosing your healthcare information in the office with current employees for quality control and operational purposes.
- Disclosing your healthcare information to your insurance company.

Your right to limit use or disclosure

You have the right to request that we do not disclose any information to specific individuals, companies, organizations in legal parameters. If you would like us to place any restrictions on your health information, please provide us with a written and signed letter. We are not required to agree to your request if legal parameters are not met.

Your right to revoke your authorization

You may revoke your consent to us at any time in writing. We will not be able to honor your request if we receive it after your health information has already been sent for any of the reasons listed above.

I have read this policy agreement, asked for clarification if needed, and agree to these terms.

Printed Patient Name: _____

Patient Signature: _____ Date: _____

Printed Guardian Name: _____

Guardian Signature: _____