Intake Form Questionnaire

Name: _____ **Subject ID#:** _____ **Date of Birth: :** _____ **Male:**__ **Female:**_____

1) To determine your eligibility to participate in the FDA study for smoking cessation or weight loss using Low Level Laser Therapy (LLLT), it is important for us to know if you currently suffer from any of the following medical conditions or are receiving certain treatments (check all that apply):

High Blood Pressure	_____	Prone to Epilepsy or Fainting	_____
Chest Pain or Heart Condition	_____	Diabetes, Cancer, Gout	_____
Rheumatic Scarlet Fever	_____	Are you on injected steroids?	_____
Thyriod Disorder	_____	Arthritis	_____
Glandular Fever or Hepatitis	_____	History of psychological or psychiatric illness?	
Asthma or Tuberculosis	_____	Do you take pain killers, sedatives, sleeping pills	_____
Indigestion, gastric	_____	Are you on any type of photo-dynamic	
Bowels, Liver Gall Bladder	_____	therapy or immunosuppressant drugs?	_____
Kidney or Bladder Disease including chronic pylitis or cystitis	_____		_____

2) When did you last see a doctor? (mm/dd/yyyy) _____

3) What was the reason?: _____

4) When was your last medical checkup? (mm/dd/yyyy): _____

5) Are you currently using any medications / supplements / herbal formulas or vitamins ?: _____ Yes (please list) _____ No

Medications	**Supplements**	**Herbal Formulas**	**Vitamins**

For Female's only

6) Are you pregnant?: _____ Yes _____ No **if so, protocol does not allow treatment of pregnant women with LLLT**

7) Date of last menstrual period: (mm/dd/yyyy) _____

If you have any doubts that LLLT is appropriate for you, consult your physician before starting treatment.

I agree that the information I have supplied is true to the best of my knowledge. I want to quit smoking , am committed to doing so, and I agree to participate in the LLLT study for smoking cessation.

Signature _____ **Date** _____

Staff Notes

_____

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Principal Investigator Signature _____ **Date** _____