

## Laser Questionnaire and Consent Form

Name \_\_\_\_\_ Date \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Please answer the following questions:

1. Are you currently pregnant or trying to conceive? Y N
2. Are you under 18 years of age? Y N
3. Do you have a pacemaker? Y N
4. Do you currently have or have you ever had thyroid cancer? Y N
5. Are you taking any heat or light sensitive medications, such as, but not limited to certain types of steroids? Y N
6. Do you currently have or have you ever had a tumor or any type of cancer? Y N
7. Is this due to an injury? Y N
8. Previous problems in this area? Y N
9. Previous therapy for this condition? Y N
10. Have you had chiropractic or any other treatment for condition? Y N
11. Do activities make you worse? Y N
12. Does your pain radiate? Y N

What is your current complaint? \_\_\_\_\_ When did it start? \_\_\_\_\_

Did the symptoms begin: Suddenly or Gradually

Are you getting: Better Same Worse

What reduces your pain? \_\_\_\_\_

What can't you do because of your symptoms? \_\_\_\_\_

What did the Doctor tell you is your diagnosis? \_\_\_\_\_

Based upon a 0 to 10 scale (0 is none and 10 is severe), what is your pain:

Right now: \_\_\_\_\_ Highest pain in past 24 hours: \_\_\_\_\_ Lowest pain in past 24 hours: \_\_\_\_\_

### Informed Consent

Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. Laser therapy utilizes visible and invisible laser radiation, therefore, appropriate eye protection is required at all times during treatment.

Effects of your treatment will continue for up to 18 hours. Individuals respond uniquely to treatment, you may see immediate results after the first treatment or depending on the severity of your condition you may require several treatments before you begin to feel results.

Increased soreness may occur after your first laser session. This is a normal healing phenomenon known as retracing. Mild bruising may occur from the soft tissue manual therapy element of your treatment program. You are required to complete this Patient Intake Form prior to treatment to ensure that laser therapy is a viable option for you.

☐ I understand the above and consent to treatment

☐ I understand that failing to complete any part of my treatment program will reduce my chances of success.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_