## PATIENT INFORMATION SHEET

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M / F**

**Full Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr’s Name / Ph. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current Health Habits** | **Yes** | **No** | **Patients Comments** | **Doctor’s Comments** |
| Did/do you smoke? |  |  |  |  |
| Did/do you drink any alcohol? |  |  |  |  |
| Are you concerned about your diet? |  |  |  |  |
| Have you been in accidents? |  |  |  |  |
| Current medications? How Long? |  |  |  |  |
| Allergies? |  |  |  |  |
| Exercise regularly? |  |  |  |  |
| Females; Are you pregnant? |  |  |  |  |
| Sleeping posture 🞏 side 🞏stomach 🞏back |  |  |  |  |

Is there a family history of: Heart Disease 🞏 Arthritis 🞏 Cancer 🞏 Diabetes 🞏 Other \_\_\_\_\_\_\_\_\_

**Present Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Pain or problem started on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pains are: Sharp 🞏 Dull 🞏 Constant 🞏 Intermittent 🞏

What activities aggravate your condition/pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is condition worse during certain times of the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition interfering with your work? \_\_\_\_ Sleep? \_\_\_\_ Daily Routine? \_\_\_\_ Other? \_\_\_\_

Is condition getting progressively worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen any other Doctors seen for this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any effective treatments? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced any side effects from the drugs and surgeries? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Symptoms:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 🞏 | Headaches | 🞏 | Pins and Needles in legs | 🞏 | Fainting |
| 🞏 | Neck Pain | 🞏 | Pins and Needles in Arms | 🞏 | Loss of Smell |
| 🞏 | Sleeping Problems | 🞏 | Numbness in Fingers | 🞏 | Loss of Taste |
| 🞏 | Back Pain | 🞏 | Numbness in Toes  | 🞏 | Diarrhea |
| 🞏 | Nervousness | 🞏 | Shortness of Breath | 🞏 | Feet Cold |
| 🞏 | Tension | 🞏 | Fatigue | 🞏 | Hands Cold |
| 🞏 | Irritability | 🞏 | Depression | 🞏 | Stomach Upset |
| 🞏 | Chest Pains | 🞏 | Lights Bothers Eyes | 🞏 | Constipation |
| 🞏 | Dizziness | 🞏 | Loss of Memory | 🞏 | Cold Sweats |
| 🞏 | Face Flushed | 🞏 | Ears Ring  | 🞏 | Loss of Balance |
| 🞏 | Neck Stiff | 🞏 | Fever | 🞏 | Buzzing in Ears |



Identify all problem areas on this diagram. Please use:

O – A circle around areas of pain

X – an x on areas of numbness and tingling

Does anything alleviate the main complaint?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## CONSENT TO LOW INTENSITY LASER TREATMENT

Low Intensity Laser Therapy (LILT) is the use of monochromatic light emission from a low intensity laser diode (250 miliwatts or less) or an array of high intensity Super Luminous Diodes (providing optical power in the 1000-2000 miliwatt range) to treat musculoskeletal injuries, chronic and degenerative conditions and to heal wounds. The light source is placed in contact with the skin allowing the photon energy to penetrate tissue, where it interacts with various intracellular biomolecules resulting in the restoration of normal cell function and enhancement of the body’s healing processes.

Low Intensity Laser Therapy improves and cures multiple pathologies in the shortest possible period of time while achieving the following goals:

1. Absence of pain.
2. Eliminate the need for drugs.
3. Restoration of mobility (normal range of motion).
4. Improve quality of life (activity levels, sleep, etc.)
5. Reduce the need for surgical intervention.

Treatments are usually scheduled 2-3 times a week or more frequently in acute cases, at least initially. Subsequent treatments are scheduled in accordance with the patient’s status. With regard to the number of treatment sessions, these may vary from 1 to 30. A minimum of 10-15 treatments is recommended. It is important to be aware that before treatment is initiated that the exact number of treatments cannot be predicted. In most cases we expect to see some change in symptomology after 3-5 sessions. There are however exceptions to this rule. Acute injuries generally respond more rapidly than chronic problems and each individual’s tissue response varies. Please do not forget that our objective is to minimize the length of treatment and the number of visits. However, on occasion even our best efforts require multiple treatments, patience and time.

Any procedure intended to help may have complications. The risk of injuries or complications from LILT treatment is substantially lower than that associated with many medical or other alternative treatments, medications, and procedures given for the same condition. However, it is the practice of this clinic to inform our patients about them. Some patients have experienced exacerbation of pain and tiredness subsequent to treatment. If this occurs, utilize pain medication, and/or ice on the area of involvement and notify the doctor/therapist prior to the next treatment. The existence of this phenomenon is due to a high sensitivity tissue response and protocols will be adjusted accordingly on your next visit. A dull achy sensation subsequent to treatment lasting less than 24 hours indicates that your tissues are reacting positively on a cellular level with the low intensity laser energy. Known contraindications to treatment: directly over the abdomen (fetus) during pregnancy, directly over the thymus gland, patients on photo-sensitive medications, cancer and radiation therapy patients (as they should only be treated by specialists). Laser cannot cause cancer, has no cytogenic effects and does not damage tissues.

I acknowledge that I have discussed, or I have had the opportunity to discuss, with my doctor the nature, purpose and procedures of LILT treatments in general, my treatment in particular, alternative treatments and procedures, material risks of those treatments and procedures, the corresponding fee schedule as well as the contents of this consent form. I consent to the low intensity laser treatments offered or recommended to me by my doctor, I intend this consent to apply to all my present and future low intensity laser treatments.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Patient Signature /(Legal Guardian) Guardian’s Relationship to Patient**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name**