Patient Intake Form

Are you a candidate for laser therapy?

Laser therapy is an FDA cleared modality for the treatment of pain and inflammation and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. This form is a tool to help your clinician determine if you are a candidate for laser therapy. If you answer yes to any of these questions you will need to discuss details of your condition with your clinician.

Please check YES or NO to the questions below

YES ☐ NO ☐ Do you have a pacemaker or any other implanted devices?

YES ☐ NO ☐ Are you pregnant?

YES ☐ NO ☐ Do you have cancer?

YES ☐ NO ☐ Are you taking medications that may increase your sensitivity to light?

YES ☐ NO ☐ Have you had a steroid injection in the last 7 days?

Patient Signature _____ Date _____

Print Patient Name _____

Notes:

The ultimate decision to recommend treatment lies with your health care provider.
Speak with your health care provider if you have further questions about therapy treatment.

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 the Patient Intake Form prior to treatment to ensure that laser therapy is a viable option for you.

YES ☐ I understand the above and consent to treatment

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

Patient Signature

Date

Print Patient Name