# CAROLINASCHIROPRACTIC
AND SPINAL REHAB

## Laser Therapy New Patient Intake Form

**Name:** _____ **Date of Birth:** ___/___/___ Today's Date: ___/___/___

**Reason for Visit:** _____

**When did your symptoms Begin?** _____

**What other treatment have you utilized?** _____

**Are your symptoms:** Getting Better No Change Getting worse

**What makes it better:** Rest Ice/heat movement Medication Other: _____

**What makes it worse:** Rest Activity Lifting Walking Sitting Other: _____

**Describe your pain:** Sharp Dull Achy Stiff Tight Shooting Stabbing Other: _____

**Previous Health History:**

**Have you had any surgeries:** Yes No If Yes: _____

**Are you currently taking any medications:** Yes No If Yes: _____

_____

**Do you have any active cancers:** Yes No **Are you Pregnant:** Yes No

**Do you have any active infections or open wounds:** Yes No

**Do you have any sensitivity to light:** Yes No

I understand any "yes" to the above questions could be a contraindication to the use of Class IV Laser Therapy. I understand goggles are required to be worn during the entire treatment of Laser therapy to avoid injury the eyes. Although rare; localized erythema, headaches and fatigue have all been reported following laser therapy treatment. The possible benefits of laser treatment include: pain relief/reduction, improved mobility and reduced swelling.

Signed: _____ Date: _____

**Office Use:**

**Patch Test:** Leg (right left) Arm (right left)
Passed Fail Performed by: _____ Date: ___/___/___