February 2019

LASER NEW PATIENT - INTAKE FORM

BEACON HILL
CHIROPRACTIC AND MASSAGE

Full Name: _____ ***M / F*** ***AHC #:*** _____

Date of Birth (M/D/Y): _____ **Age:** _____ **Occupation:** _____

Address: _____ **City:** _____ **Prov:** _____ **Postal Code:** _____

Home phone: _____ **Cell phone:** _____ **Work Phone:** _____

◯ **Single** ◯ **Married** ◯ **Divorced** ◯ **Separated** ◯ **Widowed** **Children? Y / N** **How Many?:** _____

Name of Spouse: _____ **Phone Number:** _____

Alternate Emergency Contact: _____ **Phone Number:** _____

If under 18, Name of Parents: _____

Do you consent to emails regarding appointment reminders and clinic/health information? ___ Yes ___ No

Email: _____ **Initials:** _____

How were you referred to Beacon Hill Chiropractic & Massage?

◯ Online ◯ Website ◯ Walk by ◯ Lives in area ◯ Other: _____ ◯ Person: _____

◯ Current patient: _____

Experience with Chiropractic

Have you ever been adjusted by a Chiropractor before? ◯ Yes ◯ No How long ago? _____

Doctor's name? _____ Reason for visit? _____

REASON FOR THIS VISIT

Is this visit due to or in any way related to: ◯ Job ◯ Sport ◯ Car accident ◯ Fall ◯ Chronic discomfort ◯ Injury ◯ Other

If job related, have you reported your accident to your employer? Y / N **Will this visit be part of a WCB claim**? Y / N

If motor vehicle related, will this visit be part of a MVA claim? Y / N

Please describe the reason for your visit: _____

When did this condition begin? _____ Has it gotten: ◯ Worse ◯ Better ◯ Stayed the same ◯ Comes/goes

Does this condition interfere with: ◯ Work/School ◯ Sleep ◯ Daily routine ◯ Exercise/Athletics

Please explain: _____

Have you seen anyone else for this condition? Doctor/clinician's name: _____

Type of treatment: _____ Result: _____

FAMILY HEALTH HISTORY

◯ Arthritis ◯ Depression ◯ Digestive issues/IBS ◯ High blood pressure ◯ Osteoporosis
◯ Cancer ◯ Diabetes ◯ Heart disease ◯ Multiple sclerosis ◯ Stroke

FULL NAME: _____

Please **CHECK** any current/past conditions

CARDIOVASCULAR
- ◯ Angina
- ◯ Blood clots
- ◯ Blood pressure: HIGH
- ◯ Blood pressure: LOW
- ◯ Congenital heart defect
- ◯ Hardening of arteries
- ◯ Heart attack
- ◯ Heart murmur
- ◯ Heart surgery
- ◯ Hemophilia
- ◯ Pace maker
- ◯ Poor circulation
- ◯ Stroke
- ◯ Thrombosis
- ◯ Varicose veins

RESPIRATORY
- ◯ Asthma
- ◯ Chest pain
- ◯ Difficulty breathing
- ◯ Emphysema (short of breath)
- ◯ Pneumonia
- ◯ Pulmonary hypertension
- ◯ Tuberculosis

GASTROINTESTINAL
- ◯ Constipation
- ◯ Crohn's or Colitis
- ◯ Digestive problems
- ◯ Gallbladder/Jaundice
- ◯ IBS or IBD
- ◯ Nausea/Vomiting
- ◯ Ulcers

MUSCLE/BONE/JOINT/DISC
- ◯ Ankle swelling
- ◯ Arthritis
- ◯ Back pain
- ◯ Bursitis
- ◯ Cortisone injections
- ◯ Degenerative disease
- ◯ Fractures/Breaks: _____
- ◯ Inflammation
- ◯ Osteopenia
- ◯ Osteoporosis
- ◯ Plates/Pins
- ◯ Rheumatoid arthritis
- ◯ Sciatica
- ◯ Scoliosis
- ◯ Pain b/w shoulder blades
- ◯ Spinal disc problems
- ◯ Sprain/Strain
- ◯ Trauma/Falls
- ◯ Weakness/Instability

HEAD & NECK
- ◯ Dizziness
- ◯ Ear infection
- ◯ Headache
- ◯ Hearing loss
- ◯ Neck pain
- ◯ Difficulty with swallowing
- ◯ Ringing in ears (tinnitus)
- ◯ Sinus problems
- ◯ Sleep loss
- ◯ TMJ disorder
- ◯ Vertigo
- ◯ Vision problems
- ◯ Whiplash

NEUROLOGICAL
- ◯ Alzheimer's/dimentia
- ◯ Brain injury
- ◯ Cerebral palsy
- ◯ Epilepsy
- ◯ Fainting
- ◯ Migraines
- ◯ Loss of motor control
- ◯ Meningitis
- ◯ Multiple Sclerosis (MS)
- ◯ Narcolepsy/Insomnia
- ◯ Nerve damage: _____
- ◯ Numbness in arms/legs/ hands/feet/_____
- ◯ Parkinson's/ Seizures

SKIN CONDITIONS
- ◯ Keloid/Scarring
- ◯ Psoriasis
- ◯ Shingles
- ◯ Warts

WOMEN ONLY
- ◯ Cramps/back pain
- ◯ Infertility issues
- ◯ Irregular cycles
- ◯ Menopause
- ◯ Miscarriage
- ◯ New mother
- ◯ Nursing
- ◯ Painful menstruation
- ◯ Pregnant

DIAGNOSED CONDITIONS
- ◯ ADD/ADHD
- ◯ Autoimmune disease
- ◯ Cancer: _____ _____ (radiation/chemotherapy)
- ◯ Diabetes (I / II)
- ◯ Hepatitis
- ◯ HIV/AIDS
- ◯ Hypertension
- ◯ Infectious disease: _____
- ◯ Kidney disease
- ◯ Raynaud's
- ◯ Thyroid problems
- ◯ Tuberculosis
- ◯ Urinary system issues
- ◯ Other:_____

MENTAL HEALTH
- ◯ Alcohol/drug abuse
- ◯ Anxiety
- ◯ Bipolar disorder
- ◯ Depression
- ◯ Eating disorder
- ◯ Panic attacks
- ◯ Postpartum depression
- ◯ Psychiatric issues
- ◯ PTSD
- ◯ Stress

ALLERGIES

Allergic to: _____ _____

Reaction: _____ _____

◯ EpiPen? YES / NO

MEDICATIONS/SUPPLEMENTS

Some drugs can cause neuro-musculoskeletal symptoms. It is important for our chiropractors to know what medications you are currently taking. Symptoms you present in clinic may be related to these medications. If you are unsure of your medications it is <u>imperative</u> that you let us know at your next visit.

◯ Accutane ◯ Antihistamines ◯ Corticosteroids ◯ Muscle relaxants ◯ Sulfonamides

◯ Antidepressants ◯ Blood pressure meds ◯ Immunosuppressant drugs ◯ Nerve pain-killers ◯ Sulfonylureas

◯ Antifungal meds ◯ Contraceptives ◯ Insulin ◯ Photosensitive meds ◯ Thyroid meds

◯ Pain killers (NSAIDS/Ibuprofen)

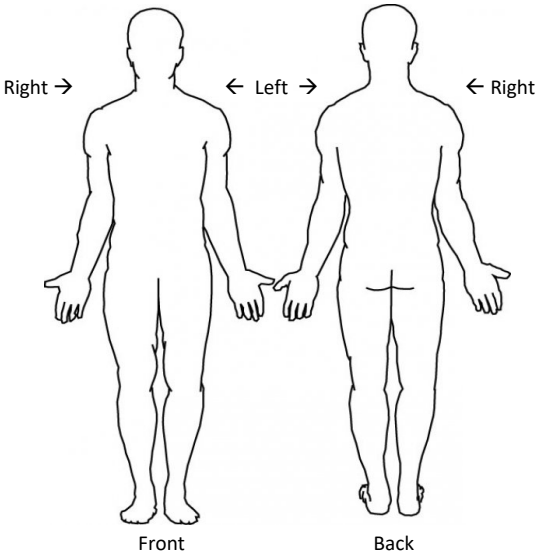
Specify Medications	Dosage	Duration	Reason

FULL NAME: _____

PAIN/DISCOMFORT DIAGRAM:

Please mark these diagrams according to where you feel pain. Please also indicate which sensations you feel by referring to the key below:

KEY
///// Stabbing
XXXX Aching
Burning
>>>> Pins/Needles
0000 Numbness



PLEASE CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

0-3 – No pain; Mild pain **4-7** – Moderate pain; medication required **8-10** – Severe pain; daily life impacted

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Laser Treatment Informed Consent

I hereby request and consent to the performance of assessments, various modes of laser therapy and related procedures, on me, by the practitioners and supportive assistant staff at Beacon Hill Chiropractic and Massage. I have had the opportunity to discuss the nature and purpose of assessments, various modes of laser therapy and related procedures with my supervising practitioner. I understand that results are not guaranteed.

I understand that cold laser therapy (LLLT) is a medical treatment that uses specific wavelengths of light to impart energy into injured cells and tissues. This energy is transformed from photon energy to biochemical energy in the cells which can then be used for repair processes in the body. The expected direct outcomes from laser therapy treatment may include reduced inflammation, reduced pain, increased cellular energy, and increased circulation to the affected area increasing tissue repair. The indirect outcomes may include increased ranges of motion, comfort and activity levels. Alternatives to LLLT include but are not limited to, exercise therapy, anti-inflammatory medications, ultrasound therapy, massage therapy, and chiropractic.

I further understand and am informed that, as in all health care, in the practice of cold laser therapy LLLT, there are some risks, including but not limited to short term aggravation of symptoms and skin irritation. When used in combination with certain medications laser therapy can cause rashes or burns and I therefore understand that I must disclose all information on my current medications to the practitioners at this clinic. Treatment over active cancer cell growth may increase the rate of tumor growth; I understand that I must disclose any history of cancer. I also understand that the laser can cause potential harm to the eyes when viewed directly and that laser safety eyewear, supplied by this clinic, must be worn by me during laser treatments. The risks of not having laser treatments include, but are not limited to, ongoing pain and inflammation, development of scar tissue, development of degenerative changes, and reduction in daily activities and overall comfort.
I do not expect the practitioners at this clinic to be able to indicate or explain all risks and complications and I wish to rely on the exercise of judgment during the course of assessment and/or procedure(s) which the practitioners feel at the time, based upon the facts known, is in my best interest.

I consent to the assessments, various modes of laser therapy and related procedures offered or recommended to me by the practitioners in this clinic. I intend this consent to apply to all my present and future care in this clinic regarding laser therapy.

_____ _____ _____

Patient Full Name (Print Legibly) *Signature* *Date (M/D/Y)*

If under the age of 18:

_____ _____ _____

Parent Name (Print Legibly) *Signature* *Date (M/D/Y)*

_____ _____

Doctor Signature *Date (M/D/Y)*