Jan 2023

LASER NEW PATIENT - INTAKE FORM

Full Name: ____ ***M / F / Other*** **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:** ______________

Current Health Conditions

Present complaint: ____

Has this condition occurred before? Y / N When? ____

Pain is: Sharp Dull Constant Intermittent Burning Numb Pins/Needles

Is your condition/pain getting worse? Y / N Other comments: ______________________________________

What makes your condition/pain worse? ____

What makes your condition/pain better? ____

Does this condition interfere with your sleep? Y / N Does it interfere with your daily routine? Y / N

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

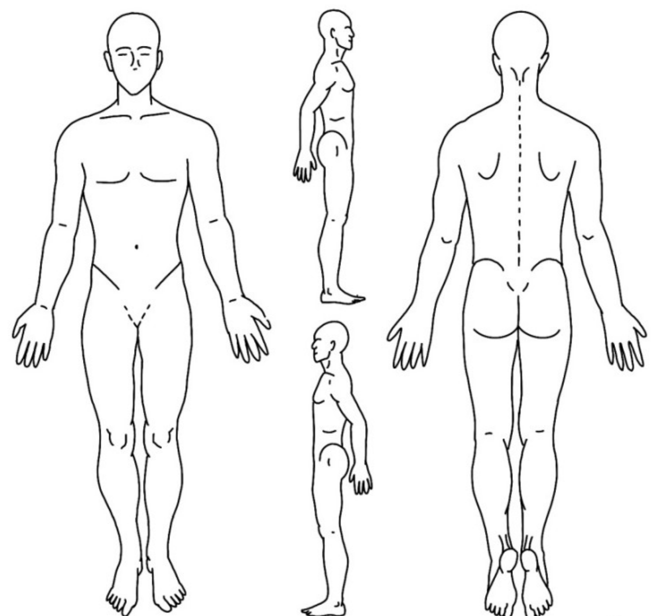
Please explain: ____

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

Type of treatment: ______________________________________ Result: __________________________________

On the pain diagram, please indicate affected area(s):

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 (mild) **4-7** (moderate) meds needed **8-10** (severe) daily life impacted

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

FAMILY HEALTH HISTORY

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

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 *imperative* *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

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 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.

**** Do <u>not</u> sign this form until you have reviewed this document with your chiropractor.**

______________________________	____________________________	_________________
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)*