Date:_____ Chart No:_____

Laser Patient Information

Last Name:_____ First Name:_____ Gender: M F

Date of Birth (dd/mm/yy): ____/____/____

Address:_____ City:_____ Postal Code:_____

Home: ( )_____ Work : ( )_____ Cell Phone: ( )_____

Email Address:_____

Occupation:_____ Employer: _____

Insurance Company: _____

Insured: Chiropractic [ ] Massage [ ] Physiotherapy [ ]

Your Chief Complaint: _____

Medical & Treatment History:

Medical Doctor Name & Address:_____

Date of last visit: _____ X-ray/MRI/Other Test: _____

Have you had any other treatments for your current injury/condition?

Explain: _____

Health History

(Please Check any of the following that apply to your current or past health)

- [] High Blood Pressure/Cholesterol
- [] Cardiac Disorders
- [] Stroke
- [] Diabetes
- [] Epilepsy
- [] Hemophilia
- [] Asthma
- [] HIV/Hepatitis/TB
- [] Headaches
- [] Digestive Problems
- [] Nausea
- [] Constipation
- [] Cancer (in past 5 years)

_____

- [] Neck Pain
- [] Back Pain
- [] Foot Pain
- [] Elbow/Wrist pain
- [] Hip/Knee Pain
- [] Arthritis
- [] Eczema/Psoriasis
- [] Dizziness
- [] Currently Pregnant
- [] Tattoos
- [] Aortic aneurysm
- [] Light Sensitivity (sunlight, tanning lights...)
- [] Other condition:_____

Current Medications:

- [ ] Tetracycline
- [ ] Accutane
- [ ] Retin A
- [ ] Celebrex
- [ ] Vioxx
- [ ] Cortisone
- [ ] Arthrotec
- [ ] Amitriptyline
- [ ] Floxin
- [ ] Cipro
- [ ] St. John's Wort
- [ ] Other: