LITECURE
Lasers for Life

Name: _____
Address: _____
_____
_____
Phone: _____
Email address: _____

Patient Intake Form and Informed Consent

Are you a candidate for laser therapy?

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. You are required to complete this intake form prior to treatment to ensure that laser therapy is a viable option for you.

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. 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 you *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.

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?

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.

Please check the following:

- ☐ I understand the above and consent to treatment.
- ☐ I understand that failing to complete any part of my treatment program will reduce my chances of success.

_____ _____
Patient Signature Date

_____ _____
Print Patient Name Physician Signature

OFFICE USE ONLY:

- ☐ Area of chief complaint _____
- ☐ Pain level: _____
- ☐ How long have you had this condition?_____
- ☐ Previous treatment _____