# A Therapeutic Effect

## Personal Data

**Patient's Name:** ______________________ **Today's Date:** ______________________

OK to leave message?

**Address:** ______________________ **Phone Number:** preferred ______________________ Y or N

______________________ other ______________________ Y or N

** Please indicate best number for us to call should we need to cancel an appointment due to weather, illness, or other emergency **

**email:** ______________________

**How should we confirm your appointments? Automated Text and/or Automated Email (please circle)**

**Date of Birth:** ____ / ____ / ____ (month / day / year)

**Sex:** Male ☐ Female ☐ Transgender ☐

**Occupation:** ______________________ **Referred by:** ______________________

OK to leave message?

**Emergency Contact:** ______________________ **Phone Number:** preferred ______________________ Y or N

**Relationship:** ______________________ other ______________________ Y or N

**Are you currently under a Physician's care?** Yes No

**If yes, please explain:** ______________________

**Please list and date any past or present injuries, accidents, or medical treatment including surgeries:**

______________________

______________________

**Are you pregnant?** Yes No ***If yes, some services may not be administered.***

**Please list all known allergies:** ______________________

**Please list all medications and supplements you are taking:** ______________________

______________________

## CANCELLATION POLICY

If you are unable to keep your appointment - for any reason - please give us as much notice as possible. For appointments broken with less than 12 hours notice, we reserve the right to charge 50% of the standard fee. Appointments that "no show" will be charged in full to cover the therapist's time.

# Laser Therapy Patient Intake Form

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. 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.

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?

Patient Signature ______________________ Date ____________

Print Patient Name ______________________

Notes:

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.