

Case History
MLS[®] Laser Therapy



Name: Last: _____ First: _____ M.I.: _____ Date: _____
Address: _____
City/State/Zip: _____
Home Phone: _____ Cell Phone: _____
E-mail address: _____ Date of Birth: _____ Sex: M or F
Occupation: _____ Employer: _____ Years Employed: _____
Is this condition employment related? Y/N Accident Related? Y/N Martial Status: M S W D
Emergency Contact: _____ Relationship: _____ Phone: _____
Who referred you for MLS Laser Therapy: _____
How did you hear about MLS Therapy: _____

What is your major complaint? _____

Other complaints? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? Y/N, explain: _____

What activities aggravate you condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily Routine Other: _____

How long has it been since you really felt good? _____

Other Doctors seen for this Condition: MD DC DO DDS DPM

Doctor's name: _____ Diagnosis: _____

X-rays: _____ Urinalysis: _____ Blood Tests: _____ Other: _____

Treatment: Medication: _____ Physiotherapy: _____

Results: _____ Length of time under care: _____

Please list ALL surgeries within the last year: _____

Have you ever been involved in an auto accident? Y/N, explain: _____

Have you ever been involved in any other accidents? Y/N, explain: _____

Have you ever had any broken bones? Y/N, explain: _____

Have you ever been diagnosed with cancer? Y/N, explain: _____

Do you have an implanted neurostimulator device? Y/N, where: _____

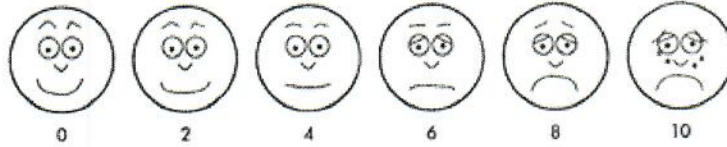
Do you have a pacemaker? Y/N _____

Are you currently taking any medications/supplements? Y/N, explain: _____

NO
PAIN

MODERATE
PAIN

WORST
PAIN

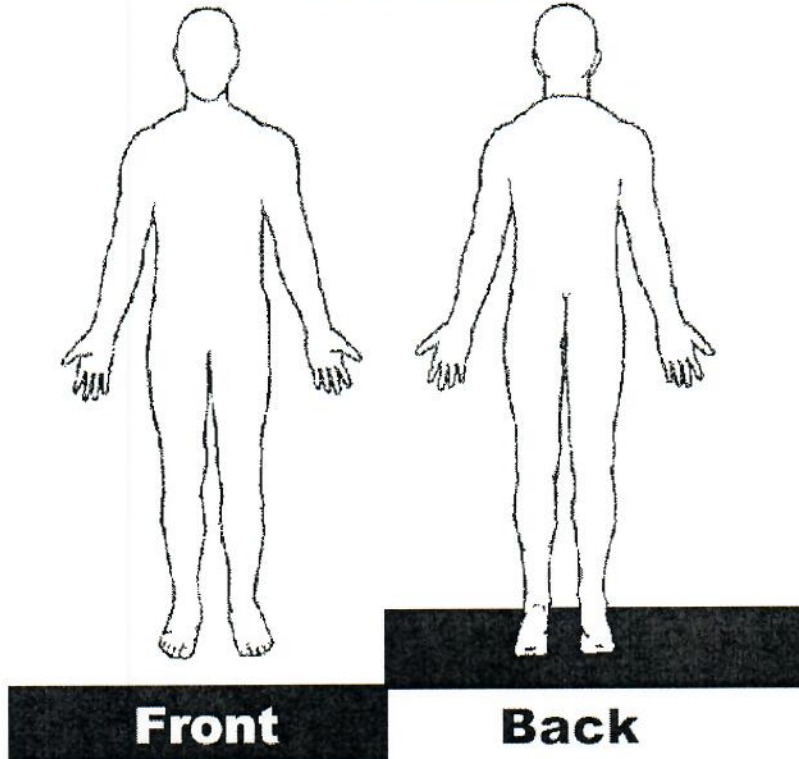


Use this chart to estimate your pain level (Circle One).

Please check any of the following that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Take medication that increases sensitivity to sunlight | <input type="checkbox"/> Take blood thinners |
| <input type="checkbox"/> Have a seizure disorder that is triggered by light | <input type="checkbox"/> Are pregnant |
| <input type="checkbox"/> Have hemorrhagic diatheses | <input type="checkbox"/> Have HIV positive history |
| <input type="checkbox"/> Been injected with steroids in the past 2-3 weeks | <input type="checkbox"/> Spinal Surgery |
| <input type="checkbox"/> Leukemia | |

Please x any area of pain



Patient Signature: _____ Date: _____

Doctor's Notes: _____

Informed Consent for Laser Therapy

Laser Therapy is a non-surgical application of laser light. Unlike most other forms of therapy, laser therapy is classified “actinotherapy” in that it results in a chemical and metabolic change of the involved tissues. As a result, laser therapy can relieve pain, decrease inflammation, accelerate the healing of tissue (biostimulation), increase blood flow and decrease tissue swelling.

Like all forms of medical treatment, there are associate risks as well as benefits. Exposure to the eyes during the procedure may result in damage of the retina. Under certain situations a superficial burn of the skin could occur. This is based upon skin pigmentation, skin discolorations (i.e. tattoos), or the use of topical creams, lotions or analgesic balms.

In order to prevent adverse reactions to laser therapy, all patients must adhere to the following guidelines:

- Wear approved safety goggles during all laser treatment session;
- Avoid the use of any topical creams, lotions or analgesic balms before or immediately after treatment;
- Inform the doctor of any skin conditions including skin sensitivity to light;
- Clean the area of treatment thoroughly prior to your scheduled appointment.

By signing below I acknowledge that I wish to proceed with laser therapy which Tri-Count Spine and Rehab has deemed to be medically necessary in the care and treatment of my condition.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED TO ME, AND ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION.

HAVING KNOWLEDGE, I KNOWINGLY AUTHORIZE TRI-COUNTY SPINE AND REHAB TO PROCEED WITH MLS LASER THERAPY AND TREATMENT.

DATED THIS _____ DAY OF _____, 20 ____.

Patient's Name

Age of Minor

Patient's Signature OR
Authorized adult of minor

Signature of Doctor

Prepare for your Treatment of Laser Therapy

- Make sure area of treatment is clean prior to your scheduled appointment
- Avoid the use of any topical creams, lotion, or analgesic balms before or immediately after treatment
- Wear approved safety goggles unless lying face down away from laser light (supplied by tech)
- Avoid wearing jewelry or any shiny objects (watches, bracelets, chains, etc.) at or around treatment area during treatment
- Wear appropriate (loose clothing) around treatment area (gowns will be supplied if necessary)

Insurance Coverage

MLS Laser Therapy is cleared for clinical use by the FDA; Insurance does not cover MLS Laser Therapy at this time. You may submit your paid receipt to your insurance company for consideration. The good news however, is that MLS Laser Therapy is very affordable to all who suffer with pain! Treatment cost begins at just \$75 for a treatment and increase based upon the extent of the injury and the number of areas which require therapy.

I HAVE READ THE ABOVE PARAGRAPH, I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED TO ME AND ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION.

Patient Signature_____

Date_____