LASER PAIN CENTER
CONFIDENTIAL PATIENT CASE HISTORY

PATIENT INFORMATION

Today's Date_____ Social Security # _____ Date of Birth _____ Age___

Name_____ Home Phone _____

Address _____ Cell Phone _____

City _____ State_____ Zip _____ Work Phone_____

Email _____ Sex □ Male □ Female

Marital Status **M S W D**

Height_____' _____" Weight _____ lbs No. of Children _____ Ages _____

Occupation_____ Employer _____

Spouse Name_____ Spouse Occupation _____

Primary Care Physician _____ Phone _____

How were you referred to our office? _____ Have you had chiropractic care before? **Y/N**

If minor, name of parent of guardian _____

Who should we contact in case of emergency? _____

CURRENT COMPLAINTS

1. Please **circle** all that apply: **NECK** / **MID BACK** / **SHOULDERS** / **LOW BACK** / **ARMS** / **LEG** / **KNEE**
HEADACHES / **NUMBNESS** / **WEAKNESS**

Other Complaints: _____

2. How long have you had this condition? _____ Have you had this condition in the past? **Y/N**

3. Activities that are affected: ❑ **Work** ❑ **Sitting** ❑ **Caring for myself/family** ❑ **Walking** ❑ **Bending**
❑ **Driving** ❑ **Sleeping** ❑ **Computer Work** ❑ **Stairs** ❑ **Housework**

4. Rate your **Pain** / **Dysfunction**: (LEAST) **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** (MOST)

5. Is this condition progressively getting worse? **Yes / No / Same**

6. How long has it been since you've really felt good? _____

7. Other Doctors you have seen for this condition: _____

8. List treatment, procedures, surgeries for this condition: _____

9. Have you had any of the following for this condition: MRI / CT scan / XRays / Injections

10. Has any other treatment helped? If so, what treatment? _____

11. What medications are you taking? _____

12. Is this condition due to an accident? If so, what type? _____

13. Have you been involved in an automobile accident within the ❑ Last year ❑ Five years ❑ Never

14. Date of last physical examination: _____ Doctor's Name: _____

HEALTH HISTORY (Check if current or in the past)

- ☐ FREQUENT HEADACHES
- ☐ FREQUENT NECK PAIN
- ☐ LOWER BACK PROBLEMS
- ☐ DISC PROBLEMS NECK/LOW BACK
- ☐ WHIPLASH
- ☐ NUMBNESS/TINGLING ARMS/LEGS
- ☐ SCOLIOSIS
- ☐ ARTHRITIS
- ☐ HEART ATTACK OR STROKE
- ☐ CONGENITAL HEART DEFECT
- ☐ ALCOHOL/DRUG ABUSE
- ☐ RHEUMATIC FEVER
- ☐ HIGH/LOW BLOOD PRESSURE
- ☐ ARTIFICIAL VALVES
- ☐ ARTIFICIAL BONES/JOINTS
- ☐ FAINTING/SEIZURES/EPILEPSY
- ☐ DIABETES
- ☐ MITRAL VALVE PROLAPSE
- ☐ HEART SURGERY
- ☐ PACEMAKER
- ☐ HEART MURMUR
- ☐ EMPHYSEMA
- ☐ PSYCHIATRIC PROBLEMS
- ☐ KIDNEY PROBLEMS
- ☐ SINUS PROBLEMS
- ☐ DIFFICULTY BREATHING
- ☐ TUBERCULOSIS
- ☐ VENERAL DISEASE
- ☐ ULCERS/COLINITIS
- ☐ IRRITABLE BOWELS
- ☐ INSULIN
- ☐ CANCER
- ☐ ANEMIA
- ☐ SHINGLES
- ☐ HIV/AIDS
- ☐ HEPATITIS
- ☐ ASTHMA
- ☐ NEUROPATHY
- ☐ OTHER _____

FAMILY HISTORY

- ☐ HEART DISEASE
- ☐ CANCER
- ☐ OSTEOPOROSIS
- ☐ HIGH BLOOD PRESSURE
- ☐ DIABETES
- ☐ OTHER _____
- ☐ STROKE
- ☐ SCOLIOSIS

ALLERGIES: Please list:

LIST SURGERIES & YEAR PERFORMED:

SOCIAL HISTORY : Do you smoke? ☐ Yes ☐ No ☐ In the Past Alcohol use? ☐ Yes ☐ No

WOMEN ONLY Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

IMPORTANT INFORMATION

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 _____

Please check any of the following that apply to you:

- ☐ Take medication that increases sensitivity to sunlight
- ☐ Have a seizure disorder that is triggered by light
- ☐ Have hemorrhagic diatheses
- ☐ Been injected with steroids in the past 2-3 weeks
- ☐ Have a cancerous lesion(s) or history of cancerous lesions
- ☐ Take anticoagulants
- ☐ Are pregnant
- ☐ Have HIV positive history
- ☐ Have a pacemaker
- ☐ Leukemia

Patient or Legal Guardian Signature _____Date_____

FINANCIAL POLICY

I understand that I am fully responsible for payment of all charges, including but not limited to, deductibles and copayments related to my care. I understand that Laser Pain Center requires full payment before any service be rendered and my balance should **not exceed $200.00** at any given time; **Laser Pain Center** does not mail monthly statements to patients. If my balance is not paid in a monthly or timely fashion, I promise to pay any and all collections, court and attorney's fees in the collection of my account. I further understand that I will pay upon notice, to **Laser Pain Center** any balance due upon my account.

Patient or Authorized Signature X **Date**

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

AUTHORIZATION AND RELEASE: I authorize payment of benefits directly to **Laser Pain Center.** I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

In addition, I have read and agree to the above **Assignments, Financial Policies, Notices, Releases and Consent forms and acknowledge Laser Pain Center does NOT accept or participate in any insurance plans and will not submit any bills or information to any insurance company**.

The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Patient or Authorized Signature X **Date**

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

I, _____ have read a copy of **Laser Pain Center's** notice of **Patient Privacy Practices**.

The patient understands and agrees to allow this chiropractic office to use their **Patient Health Information** for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the **privacy of your Patient Health Information**, we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information: _____

Patient or Authorized Signature X **Date**

LASER PAIN CENTER

Patient Name _____ Date _____

PATIENT INFORMED CONSENT

Before you receive care as a patient of Laser Pain Center, it is important that you read this Consent and understand the nature of treatment. Laser Pain Center utilizes a multidisciplinary approach to health and wellness. Treatment usually involves a blend of laser therapy, acupuncture, herbal medicine, and manual medicine. To understand the risk associated with care, you need to understand these unique modalities.

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

Like all forms of medical treatment, there are associate risks as well as benefits. Laser 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. To prevent adverse reactions to laser therapy, all patients must adhere to the guidelines for care supplied separately.

"Acupuncture" means a form of health care performed by the insertion and removal of specialized needles, with or without the use of supplemental techniques, to specific areas of the human body. *See* Ohio Statute 4762.

Manual medicine (or chiropractic care) involves the adjustment, manipulation and treatment of your body in which vertebral subluxations and other malpositioned articulations may be interfering with the normal generation, transmission and expression of nerve impulse between the brain, organs and tissue cells, thereby causing disease. Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health.

"Chiropractic physicians" examine, analyze, and diagnose the human living body and its disease by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests and (d) other chiropractic methods. *See* Ohio Statute 4734.01.

The undersigned Patient understands and acknowledges that there are risks associated with the application of laser chiropractic medicine, chiropractic care, acupuncture, therapy including, but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, fracture(s), mobility disruption, paralysis, pneumothorax, spinal injury, stroke, vision disturbances and others. The most common side effect following any treatment is an ache or stiffness at the site of the treatment.

I, hereby give authorization for **consent of treatment** to **Laser Pain Center** and whomever they may designate as their assistants to perform and administer therapy and treatment as they deem necessary.

I, the undersigned Patient, understand the risks and limitations associated with treatment at Laser Pain Center and application of therapeutic modalities such as Laser, heat, ice, ultrasound, traction, muscle stimulation, acupuncture, herbal medicine, chiropractic and others treatments by **Laser Pain Center**. **All my questions have been answered in detail and I fully understand and certify that no guarantee or assurances have been made to the results or outcome from treatment that may or will be rendered.**

Patient or Authorized Signature X **Date**

REVIEW OF SYSTEMS - LASER PAIN CENTER

Do you have: (please check all that apply):

Constitutional:
❑ Fevers ❑ Weight loss ❑ Difficulty sleeping ❑ Tiredness or fatigue ❑ Chills ❑ Night sweats ❑ **None**

Eyes:
❑ Flashing lights or "stars" ❑ Blind spots ❑ Double vision ❑ **None**

Ears, Nose, Throat, Mouth:
❑ Earache or discharge ❑ Ringing in ears ❑ Difficulty hearing ❑ Nose bleeds ❑ Sinusitis ❑ Hoarseness
❑ Sores in mouth ❑ Sore throats ❑ **None**

Cardiovascular:
❑ Chest pain ❑ Squeezing or tightness in chest ❑ Angina ❑ Need to sleep with head of the bed elevated
❑ Cramps in buttocks, thighs or calves when walking ❑ Shortness of breath at rest or walking/climbing
❑ Palpitations or fluttering heart ❑ Poor circulation ❑ Gangrene ❑Swelling of hands, face, legs or feet
❑High cholesterol ❑ **None**

Respiratory:
❑ Cough ❑ Sputum production ❑ Coughing up blood ❑ Pleurisy ❑ Wheezing ❑ Asthma ❑ **None**

Gastrointestinal:
❑ Nausea or vomiting ❑Diarrhea ❑ Constipation ❑Abdominal pain ❑Vomiting of blood ❑Very dark or light stool ❑ Jaundice ❑Liver or gall bladder problems ❑Colitis or other bowel problems ❑Bleeding from rectum ❑Ulcer ❑ **None**

Genitourinary:
❑ Blood in urine or very dark urine ❑ Get up at night to urinate ❑ Burning with urination ❑ Unusual urgency to urinate ❑ Difficulty in getting urine stream started ❑ Kidney stones ❑ Prostate problems ❑ Bladder problems ❑ Albumin or protein in urine ❑ Pus in urine ❑ Infection in urine ❑ Large amounts of urine or very frequent urination ❑ **None**

Musculoskeletal:
❑ Low back pain ❑ Neck pain ❑ Muscle ache ❑ Joint pain ❑ Mid back pain ❑ Shoulder/arm pain ❑ Hip/leg pain ❑ Arthritis ❑ **None**

Neurological:
❑ Headaches ❑ Drooping of face ❑ Loss of strength in hands, arms, legs, feet ❑ Numbness/tingling
❑Seizures ❑ Loss of consciousness ❑ Dizziness ❑ Fainting spells ❑ **None**

Skin:
❑ Rashes ❑ Skin ulcers ❑ Nodules on skin ❑ **None**

Emotional/Psychiatric:
❑ Depression ❑ Anxiety ❑ Psychiatric problems ❑ **None**

Endocrine:
❑ Enlarged thyroid ❑ Sweating ❑ Diabetes ❑ Excess thirst ❑ Change in appetite ❑ Feeling unusually hot or cold ❑ Flushing ❑ Abnormal menses ❑ Post-menopausal ❑ **None**

Hematologic/Lymphatic/Oncologic:
❑ Anemia ❑ Iron deficiency ❑ Enlarged lymph glands ❑ Easy bruising ❑ Cancer ❑ **None**

Allergic/Immunologic:
❑ Hay fever ❑ Seasonal allergies ❑ Other_____ ❑ **None**

Patient Signature	**Date**	**Physician Signature**