LASERVIBE™ THERAPY CENTER

Patient Information

Date: _____ File #: (office use) _____

Name: _____

E-Mail :_____

Phone:_____Cell:_____

Address: _____

_____,_____,_____

City State Zip

Sex: ❑M ❑F Age: _____ DOB:____/_____/_____

❑Single ❑Married ❑Widowed ❑Separated ❑Divorced

SSN:_____

Occupation:_____

Employer:_____

Spouse's Name:_____

Spouse's Employer: _____

Family Physician: _____

Office Use Only: (Circle What Applies)

Patient Records

Pt. brought disc or hard copies:

X-Ray MRI CT Report Other: _____

Need to Request:

X-Ray Images **X-Ray Report**

MRI Images **MRI Report**

CT Images **CT Report**

Date of Records: _____

Location: _____

Physician: _____

Take X-Rays **Staff Initials: _____**

How did you hear about us?

- ☐ Referral from doctor:_____
- ☐ Referral from patient:_____
- ☐ Television channel:_____
- ☐ Internet website:_____
- ☐ Newspaper:_____
- ☐ Other:_____

Chief Complaint (Write Down Your #1 Chief Complaint)

#1 Chief Complaint:_____

Date of Injury/Onset of Pain: _____

Is this condition getting progressively worse? ❑Yes ❑No ❑I Do Not Know

Circle on the picture where you have pain and draw lines where the pain radiates.→→→→ →→→→ →→→→ →→→→ →→→→ →→→→ →→→→ →→→→

Radiates to? ❑Shoulders ❑Arms ❑Hands ❑Fingers ❑Legs ❑Feet ❑Knees

Type of Pain? ❑Sharp ❑Dull ❑Numb ❑Aching ❑Stiff ❑Shooting ❑Throbbing ❑Burning ❑Tingling ❑Cramping ❑Swelling ❑Other_____

How often do you have the pain?_____

Is it constant? ❑Y ❑N Comes and goes? ❑Y ❑N

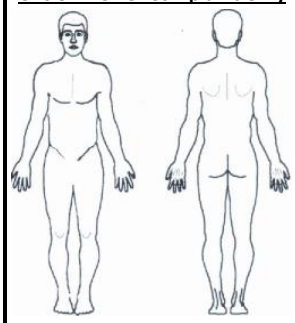
What makes the pain worse? _____ Better? _____

Does it interfere with your…? ❑Work ❑Sleep ❑Daily Routine ❑Recreation

Activities/movements that are painful? ❑Sitting ❑Standing ❑Walking ❑Bending ❑Lying down

Please Circle One Number: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain**

Circle #1 Chief Complaint Only



Surgical History ❑ I **DO NOT** have a history of any previous surgeries.

Type of Surgery/Year/Surgeon?_____

_____

Treatment History

Past treatments for this condition? ❑Medication ❑Physical Therapy ❑Chiropractic ❑Injections ❑Acupuncture ❑Other _____

Name of doctors who have treated you for your condition?_____

Past Medical History

Alcoholism ☐ Y ☐ N	Coronary Art Dis ☐ Y ☐ N	Migraines ☐ Y ☐ N
Anemia ☐ Y ☐ N	Diabetes ☐ Y ☐ N	Mononucleosis ☐ Y ☐ N
Arthritis ☐ Y ☐ N	Emphysema ☐ Y ☐ N	Multiple Sclerosis ☐ Y ☐ N
Asthma ☐ Y ☐ N	Epilepsy/Seizure ☐ Y ☐ N	Osteoporosis ☐ Y ☐ N
Atrial Fibrillation ☐ Y ☐ N	Gout ☐ Y ☐ N	Pacemaker ☐ Y ☐ N
Birth Defects ☐ Y ☐ N	Headaches ☐ Y ☐ N	Parkinson's ☐ Y ☐ N
Bladder Problems ☐ Y ☐ N	Heart Disease ☐ Y ☐ N	Prostate Issues ☐ Y ☐ N
Blood Clots-legs ☐ Y ☐ N	Hemophilia ☐ Y ☐ N	Psychological Dis. ☐ Y ☐ N
Blood Clots-lungs ☐ Y ☐ N	Hepatitis A / B / C ☐ Y ☐ N	Recurrent Infection ☐ Y ☐ N
Blood Pressure-high ☐ Y ☐ N	Hernia ☐ Y ☐ N	STD ☐ Y ☐ N
Blood Pressure-low ☐ Y ☐ N	Herpes ☐ Y ☐ N	Stroke CVA / TIA ☐ Y ☐ N
Bowel Issues ☐ Y ☐ N	HIV/AIDS ☐ Y ☐ N	Thyroid ☐ Y ☐ N
Cancer _____ ☐ Y ☐ N	Kidney/Renal Dis ☐ Y ☐ N	Ulcer ☐ Y ☐ N
Cong. Heart Failure ☐ Y ☐ N	Liver Disease ☐ Y ☐ N	Other _____
	Lung Problems ☐ Y ☐ N	_____

Current Medications/Vitamins: ____ See List (I am attaching my medication list)

_____

Social History Exercise? ❑None ❑Moderate ❑Daily Children? ❑Yes ❑No

Habits? Smoking # packs_____ Alcohol # drinks_____ Coffee/Caffeine # cups_____

Current Review of Body Systems (Please check box if **NORMAL**)

Normal	Problem Details	Normal	Problem Details
❑Musculoskeletal	_____	❑Stomach	_____
❑General Health	_____	❑Bladder	_____
❑Eyes	_____	❑Blood	_____
❑Ears/Nose/Throat	_____	❑Neurological	_____
❑Thyroid	_____	❑Psychiatric	_____
❑Breathing	_____	❑Skin	_____
❑Heart	_____	❑Allergic	_____

Are You Pregnant? ❑Y ❑N **Are You Nursing? ❑Y ❑N**

Initial on the Lines Below (You will not be seen by the doctor without initialing and signing)

_____ I make my own medical/financial decisions

_____ I do NOT have a Durable Power of Attorney (Person in charge of my medical decisions)

_____ I do NOT have a Financial Power of Attorney (Person in charge of my financial decisions)

By signing below, I assume full responsibility that all information is accurate, this is my consent for treatment, and I agree to inform this office of any changes in my personal medical status.

Patient Signature: _____ Date: _____