

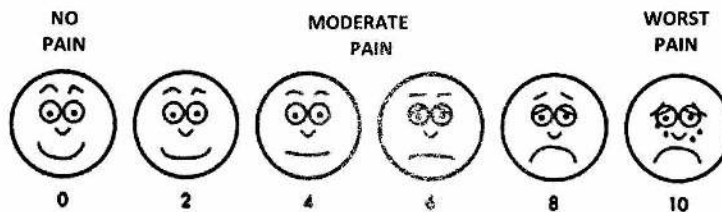
Existing Patient Registration

MLS Laser Therapy



Name _____
 Address _____
 City/State/Zip _____
 Home Phone _____ Cell Phone _____
 E-mail address _____ Date of Birth _____
 Primary complaint _____

Length of time with this condition _____
 How did you hear about MLS Laser Therapy? _____



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

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:

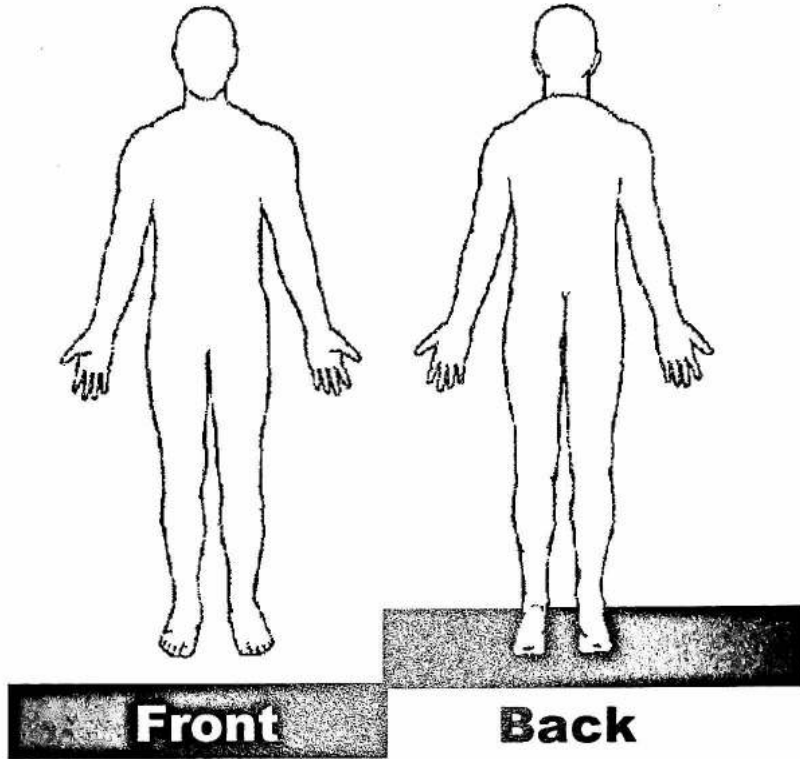
- | | |
|---|--|
| <input type="checkbox"/> Take medication that increases sensitivity to sunlight | <input type="checkbox"/> Take anticoagulants |
| <input type="checkbox"/> Have a seizure disorder that is triggered by light | <input type="checkbox"/> Are pregnant |
| <input type="checkbox"/> Have hemorrhagic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

Please list medications you are currently taking:

Patient Signature: _____

Date: _____

Please x any area of pain



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Doctor's Notes _____

