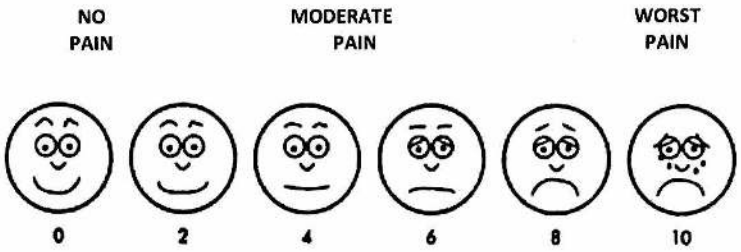
Case History
MLS® Laser Therapy

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 you 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: _____
_____
_____

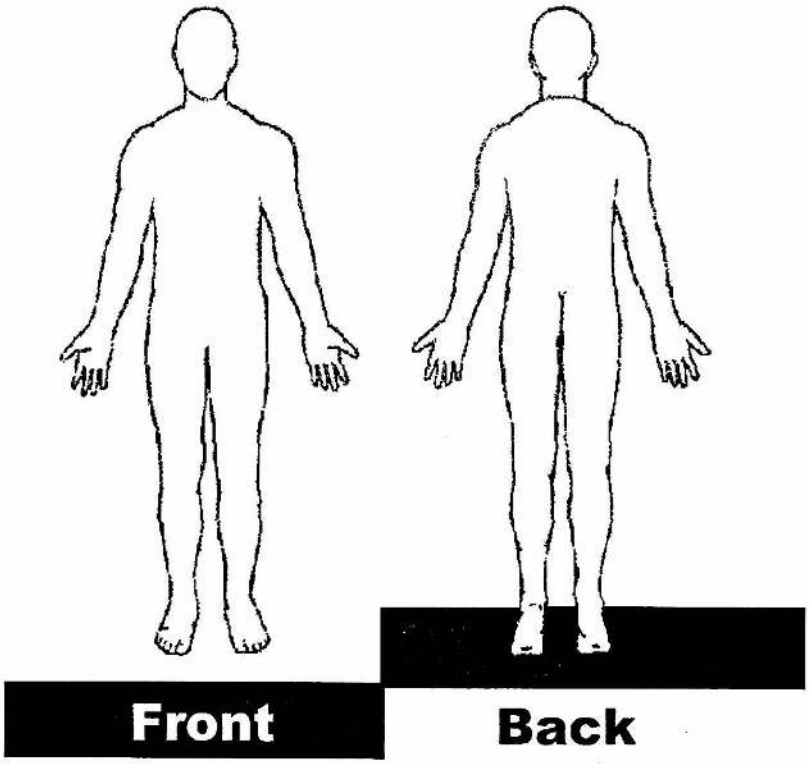


Use this chart to estimate your pain level (Circle One).

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
___ Leukemia
___ Take blood thinners
___ Are pregnant
___ Have HIV positive history
___ Spinal Surgery

Please x any area of pain



Patient Signature: _____ Date: _____

Doctor's Notes: _____

_____

_____

_____

