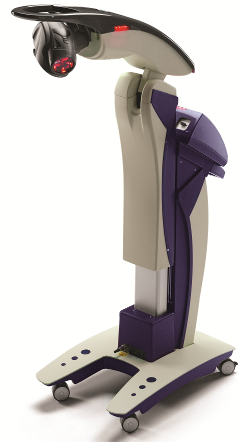
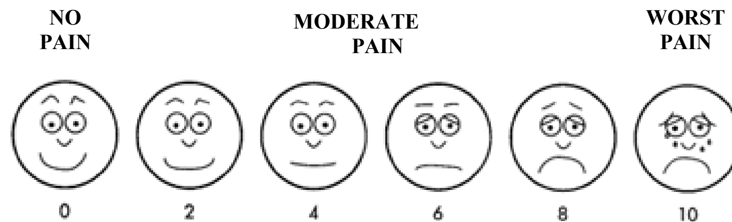


Existing Patient Registration

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:

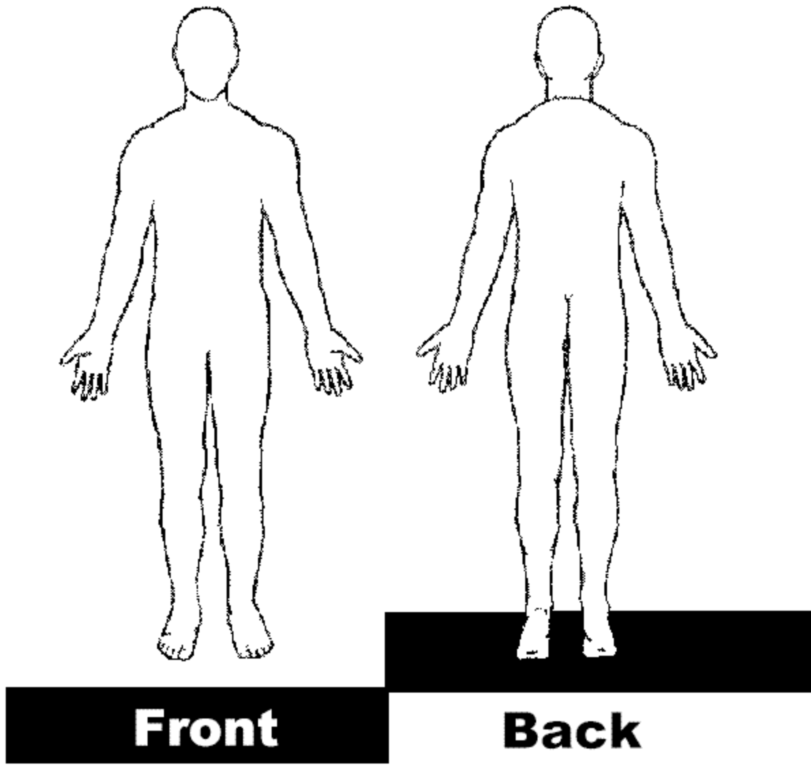
___ Take medication that increases sensitivity to sunlight
___ Have a seizure disorder that is triggered by light
___ Have hemorrhagic diatheses
___ Been injected with steroids in the past 2-3 weeks
___ Have a cancerous lesion(s) or history of cancerous lesions
___ Take anticoagulants
___ Are pregnant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

Please list medications you are currently taking:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Patient Signature: _____________________________________ Date: ____________

Please x any area of pain



Doctor's Notes ____

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