

Optimum Performance Centre

**CONFIDENTIAL PATIENT INFORMATION – LASER THERAPY**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Birth Date: M \_\_\_\_\_ /D \_\_\_\_\_ /Y \_\_\_\_\_ Gender:  Male  Female  
Address: \_\_\_\_\_  
City / Town: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Number of Children: \_\_\_\_\_ Spouse / Parent: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
WCB Claim:  Yes  No Motor Vehicle Accident:  Yes  No  
How did you hear about us?: \_\_\_\_\_

Previous Laser Therapy:  Yes  No  
Name of Laser Therapist: \_\_\_\_\_  
Medical Doctor: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_  
Chiropractor: \_\_\_\_\_ Presently Being Treated:  Yes  No  
Physiotherapist: \_\_\_\_\_ Presently Being Treated:  Yes  No  
Medication or Prescription Drugs: \_\_\_\_\_  
Certain antibiotics, water pills, anti-inflammatory medication, sleeping pills, acne or psychiatric medications or chemotherapy can be highly photosensitive  
Vitamins / Minerals: \_\_\_\_\_  
Female: Pregnant  Yes  No

Reason for Appointment: \_\_\_\_\_  
Area(s) of Complaint:  Neck  Shoulder  Mid-back  Low back  
 Other: \_\_\_\_\_  
Date Symptoms Appeared or Accident Happened: \_\_\_\_\_  
Recurring or Past Problem:  Yes  No  
Intensity:  Mild  Moderate  Severe  
Timing:  Constant  Comes and goes  
Interferes With:  Work  Sleep  Daily Routine  Other: \_\_\_\_\_  
Aggravating Factors: \_\_\_\_\_

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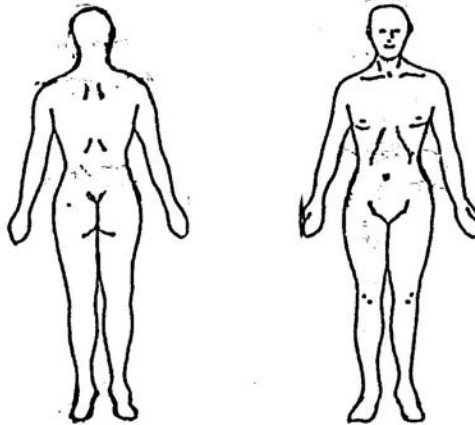
Previous Accidents or Injuries (car, falls, sports, etc.): \_\_\_\_\_

Exercise / Sport Involvement:  Yes  No

Type / Frequency: \_\_\_\_\_

Please indicate the location and type of pain you are currently experiencing:

Aching:        *aaaaaa*  
Sharp:         *^^^*  
Burning:       *xxxxx*  
Shooting:     *+++++*  
Stabbing:      *///////*  
Numbness:     *nnnnn*  
Spasm:         *oooooo*



Family Medical History:

Include parents (M, F), children (C), sibling (S), grandparents (GM, GF)

\_\_\_ High Blood Pressure    \_\_\_ Stroke            \_\_\_ Cancer            \_\_\_ Arthritis  
\_\_\_ Heart Disease         \_\_\_ Diabetes         \_\_\_ Genetic Disease / Specify: \_\_\_\_\_  
\_\_\_ Other: \_\_\_\_\_

Habits:

	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sleep: Hours: \_\_\_\_\_

<input type="checkbox"/>	Light	<input type="checkbox"/>	Deep	<input type="checkbox"/>	Restless
<input type="checkbox"/>	Side	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	Back

Exercise

Type/Frequency: \_\_\_\_\_

## Optimum Performance Centre

**Check those you are suffering from or have recently suffered from:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allergy                | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Loss of Smell   |
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Loss of Taste   |
| <input type="checkbox"/> Neck Pain              | <input type="checkbox"/> Numbness in Fingers      | <input type="checkbox"/> Feet Cold       |
| <input type="checkbox"/> Sleeping Problems      | <input type="checkbox"/> Numbness in Toes         | <input type="checkbox"/> Hands Cold      |
| <input type="checkbox"/> Nervousness            | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Stomach Upset   |
| <input type="checkbox"/> Tension                | <input type="checkbox"/> Rapid heart beat         | <input type="checkbox"/> Constipation    |
| <input type="checkbox"/> Irritability           | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Diarrhea        |
| <input type="checkbox"/> Chest Pains            | <input type="checkbox"/> Depression               | <input type="checkbox"/> Cold Sweats     |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Light Bothers Eyes       | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Neck pain or stiffness | <input type="checkbox"/> Loss of Memory           | <input type="checkbox"/> Fainting        |
| <input type="checkbox"/> Face Flushed           | <input type="checkbox"/> Ears Ring                | <input type="checkbox"/> Fever           |
| <input type="checkbox"/> Neck Stiff             | <input type="checkbox"/> Buzzing in Ears          |  |

### **PAYMENT IS EXPECTED AT TIME OF VISIT**

**Person responsible for payment** \_\_\_\_\_

I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered will be immediately due and payable.

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Name of Guardian Authorizing Care** \_\_\_\_\_

**Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_