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.): _____

_____

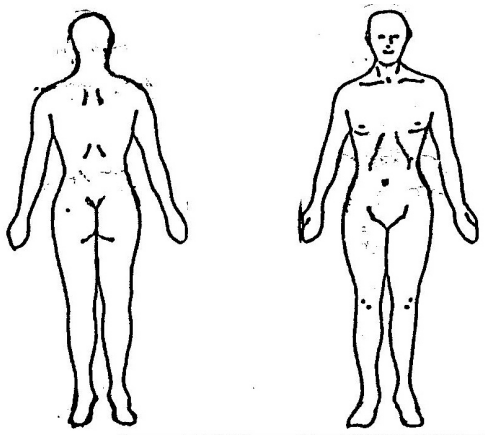
_____

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	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Exercise	☐	☐	☐	☐

Type/Frequency: _____

Sleep: Hours: _____
☐ Light ☐ Deep ☐ Restless
☐ Side ☐ Stomach ☐ Back

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

☐ Allergy	☐ Pins and Needles in Legs	☐ Loss of Smell
☐ Headaches	☐ Pins and Needles in Arms	☐ Loss of Taste
☐ Neck Pain	☐ Numbness in Fingers	☐ Feet Cold
☐ Sleeping Problems	☐ Numbness in Toes	☐ Hands Cold
☐ Nervousness	☐ Shortness of Breath	☐ Stomach Upset
☐ Tension	☐ Rapid heart beat	☐ Constipation
☐ Irritability	☐ Fatigue	☐ Diarrhea
☐ Chest Pains	☐ Depression	☐ Cold Sweats
☐ Dizziness	☐ Light Bothers Eyes	☐ Loss of Balance
☐ Neck pain or stiffness	☐ Loss of Memory	☐ Fainting
☐ Face Flushed	☐ Ears Ring	☐ Fever
☐ Neck Stiff	☐ 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**_____