LASER INTAKE FORM

Simply Health Chiropractic E5028 US Highway 14, Spring Green, WI 53588

Patient Name: _____ DOB: __ / __ / ____ Today's Date: __ / __ / ____

PRIMARY REASON YOU WANT LASER THERAPY:

❑ Chronic Discomfort/Pain ❑ Sports Performance ❑ New Discomfort/Pain ❑ Wellness

IS THIS PROBLEM:

❑ Less than 5 days old ❑ More than 5 days ❑ Less than 30 days ❑ More than 30 days

❑ Getting better ❑ Not changing ❑ Getting Worse

IS YOUR PAIN LOCALIZED OR GENERAL?

❑ Localized - small, centralized area of pain - I can point right to it ❑ Generalized - involves all or most of a body part

HOW OFTEN DOES THE PAIN OCCUR?

❑ Changes in severity but always present ❑ Intermittent comes and goes ❑ Constant

INDICATE ALL OF THE FOLLOWING THAT DESCRIBE YOUR PAIN: *(select all that apply)*

❑ Dull ❑ Squeezing ❑ Tingling ❑ Radiates down arm (RIGHT LEFT BOTH)

❑ Achy ❑Hot/Burning ❑ Tender to touch ❑Radiates down leg (RIGHT LEFT BOTH)

❑ Sharp ❑ Stinging or Jabbing ❑ Shooting ❑ Numb ❑ Throbbing

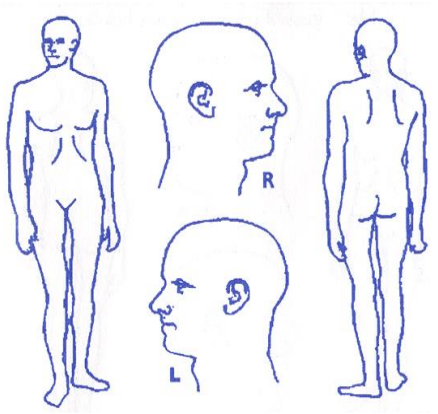
DOES CONDITION HAVE OR CAUSE:

❑ Weakness ❑ Swelling ❑ Balance Problems ❑ Cramping ❑ Not Applicable

DO YOU USE THE FOLLOWING PHYSICAL AIDES FOR ANY CONDITION?

CANE	CRUTCHES	WALKER	WHEELCHAIR/SCOOTER
❑ Never	❑ Never	❑ Never	❑ Never
❑ Occasionally	❑ Occasionally	❑ Occasionally	❑ Occasionally
❑ Often	❑ Often	❑ Often	❑ Often
❑ Always	❑ Always	❑ Always	❑ Always

Circle the EXACT area where pain/discomfort is located RIGHT NOW:



CHOOSE THE LINE THAT BEST DESCRIBES THE PAIN YOU FEEL RIGHT NOW: *(Select only one per row)*

AT REST:	WITH MOTION:
❑ ABSENT	❑ ABSENT
❑ VERY MILD- Very light, barely noticeable pain	❑ VERY MILD- Very light, barely noticeable pain
❑ UNCOMFORTABLE- Minor pain, irritating	❑ UNCOMFORTABLE- Minor pain, irritating
❑ TOLERABLE- Moderate pain, however you have adapted to it	❑ TOLERABLE- Moderate pain, however you have adapted to it
❑ DISTRESSING- Strong, deep pain, like an average toothache	❑ DISTRESSING- Strong, deep pain, like an average toothache
❑ INTENSE- Dominates your senses most some of the time	❑ INTENSE- Dominates your senses most some of the time
❑ VERY INTENSE- Dominates your senses at least half of the time	❑ VERY INTENSE- Dominates your senses at least half of the time
❑ HORRIBLE- Pain so intense you can no longer think clearly at all	❑ HORRIBLE- Pain so intense you can no longer think clearly at all
❑ UNBEARABLE- Pain so intense you demand pain killers or surgery no matter the risk	❑ UNBEARABLE- Pain so intense you demand pain killers or surgery no matter the risk
❑ UNIMAGINABLE- Pain so intense you will go unconscious shortly	❑ UNIMAGINABLE- Pain so intense you will go unconscious shortly

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CHECK THE BOX(ES) THAT CORRESPONDS TO THINGS THAT MAKE YOUR PAIN WORSE: *(Select all that apply)*

- ❑ Looking upward
- ❑ Looking downward
- ❑ Stretching Exercises
- ❑ Standing
- ❑ Bending Over
- ❑ Flexion – Bending motion that decreases the angle of the joint
- ❑ Extension – Straightening motion that increases the angle of the joint
- ❑ Abduction – Motion of body part away from body
- ❑ Adduction – Motion of body part toward the body
- ❑ Pulling
- ❑ Pushing
- ❑ Pronation – Twisting Left
- ❑ Lifting an object
- ❑ Lying on Right Side
- ❑ Lying on Left Side
- ❑ Getting up from sitting down
- ❑ Getting up from lying down
- ❑ Sitting down into a chair
- ❑ Sitting for short periods
- ❑ Sitting for long periods
- ❑ Walking for short distances
- ❑ Walking for long distances
- ❑ Athletic Exercises – Comment Below
- ❑ Driving for long distances
- ❑ Computer Use
- ❑ Repetitive motions (Be specific in comments)
- ❑ Almost any movement
- ❑ Rotation – Twisting Right

COMMENTS: _____

_____

CHECK ALL THE BOX(ES) THAT CORRESPONDS TO THE THINGS THAT MAKE YOUR PAIN BETTER: *(Select all that apply)*

❑ Nothing ❑ Physical Therapy or Massage ❑ Over the counter medications ❑ Prescription medications

❑ Other: _____

PLEASE LIST ALL PAIN MEDICATIONS THAT YOU ARE CURRENTLY TAKING FOR THIS COMPLAIN (INCLUDE NAME, DOSE, AND HOW OFTEN):

_____

_____

_____

RANGE OF MOTION: *(Select only one per row)*

1. Describe range of motion AT REST in left column
2. Move affected area in natural range of motion
3. Stop where pain begins to increase – describe ROM on scale on the right.

AT REST	WITH MOTION
❑ 0 None	❑ 0 None
❑ 1 Poor	❑ 1 Poor
❑ 2 Fair	❑ 2 Fair
❑ 3 Good	❑ 3 Good
❑ 4 Normal	❑ 4 Normal

EVALUATION OF CONDITION BY A HEALTHCARE PROFESSIONAL:

Tell us what specialist you have consulted for your current pain problems AND HOW LONG: *(put NA if you have not seen healthcare profession for this condition)*

- ❑ MD- Medical Doctor _____
- ❑ DO- Doctor of Osteopathy _____
- ❑ NP- Nurse Practitioner _____
- ❑ PA- Physician Assistant _____
- ❑ DC- Doctor of Chiropractic _____
- ❑ ND- Naturopathic Doctor _____
- ❑ LAc- Licensed Acupuncturist _____
- ❑ LMT- Licensed Massage Therapist _____
- ❑ PT- Physical Therapist _____

TESTS YOU'VE HAD FOR THIS CONDITION WITHIN THE LAST YEAR:

❑ X-Ray ❑ MRI ❑ Both ❑ Neither

❑ Other: _____