RIVER STONE

Date _____

LASER PHOTOBIOMODULATION

Confidential Patient Case History Form

Name: _____ ❒ Male ❒ Female

Email: _____ Age:____ Birthdate: (Day)_____ (Month)_____ (Year)_____

AB Health Care #: _____ Home Phone: _____ Cell Phone: _____

Medical Doctor: _____ Doctor Phone #: _____

Emergency Contact Name: _____ Phone #: _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- ❒ High blood pressure
- ❒ Low blood pressure
- ❒ Chronic congestive heart failure
- ❒ Heart attack
- ❒ Phlebitis / varicose veins
- ❒ Stroke / CVA
- ❒ Pacemaker or similar device
- ❒ Heart disease
- ❒ Dizziness / vertigo
- ❒ Seizures
- ❒ Blood clots

Is there a family history of any of the above? ❒Yes ❒No

Head and Neck
- ❒ History of headaches
- ❒ History of migraines
- ❒ Vision problems
- ❒ Vision loss
- ❒ Ear problems
- ❒ Hearing loss

Women
- ❒ Pregnancy
  Due Date: _____
- ❒ Previous Pregnancy Complications:
  Describe: _____
- ❒ Menopausal problems:
  Describe: _____
- ❒ Menstrual problems:
  Describe: _____
- ❒ Gynecological conditions
  Describe: _____

Respiratory
- ❒ Asthma
- ❒ Bronchitis
- ❒ Emphysema
- ❒ Chronic Cough
- ❒ Shortness of breath

Is there a family history of any of the above? ❒ Yes ❒ No

Muscle/Joint
- ❒ Neck
- ❒ Back (❒ lower ❒ mid ❒ upper)
- ❒ Shoulders
- ❒ Elbow
- ❒ Wrist / Hand
- ❒ Hip
- ❒ Knee
- ❒ Ankle / Foot
- ❒ Spine

Infectious Conditions
- ❒ Skin Conditions
  Describe: _____
- ❒ Respiratory Conditions
  Describe: _____
- ❒ Hepatitis

Skin Conditions
- ❒ Eczema
- ❒ Psoriasis
- ❒ Rash
- ❒ Warts
- ❒ Open Sores

Digestive
- ❒ Constipation
- ❒ Crohn's Disease
- ❒ Colitis
- ❒ Irritable Bowel Syndrome
- ❒ Ulcers

Other
- ❒ Loss of sensation
  Where? _____
- ❒ Diabetes
  Onset: _____
  Type: _____
- ❒ Allergies / hypersensitivity
  What? _____
- ❒ Epilepsy
- ❒ Cancer
  Type/Location: _____
- ❒ Arthritis
  Type/Location: _____
- ❒ Hemophilia
- ❒ Fibromyalgia
- ❒ Chronic fatigue
- ❒ Scoliosis
- ❒ Polio / Post Polio
- ❒ Osteoporosis
- ❒ Depression
- ❒ Anxiety/Stress

Men
- ❒ Enlarged Prostate
- ❒ Libido Issues
- ❒ Other

_____

Do you have any medical conditions not listed above? ❒ Yes ❒ No

If yes, please describe: _____

Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of?

❒ Yes ❒ No *If yes, please describe:* _____

For what condition or reason are you seeking treatment today? _____

_____

Are you presently taking any prescribed medication(s)? ❒ Yes ❒ No

If yes, please record the medication(s) and the condition(s) for which it is being used if known.

_____

Are you pregnant? ❒ Yes ❒ No

Laser Therapy Contrindications:

Pregnancy — LED and NovoThor treatments are safe. Laser (3B) treatments may be performed except over the belly and lower back.

Cancer — LED and Laser (3B) treatments will not be performed over any cancer. Supportive therapy eg. pain relief and lymphatic drainage may be performed.

Eyes — LED and NovoThor treatments are safe. Lasers (3B) are potentially harmful to the retina if viewed directly.

Precautions:

Photo-sensitive medications — Patients taking medications which cause photo-sensitive reactions should advise the laser technician.

I acknowledge that no assurance or guarantee has been provided as to the results of the treatment. I understand that the Laser Technician must be fully aware of my existing medical conditions. I have completed my medical history form as provided by River Stone and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Laser Technician updated on my medical history. I give consent for my treatment notes to be read by the other health care professionals at River Stone. The information I have provided is true and complete to the best of my knowledge.

For insured clients when applicable:
I hereby consent to direct billing so that River Stone Wellness Centre may bill my health insurance company and have that company pay River Stone directly for my treatments. By signing this I also state that I will pay any outstanding fees for treatments received that are not covered by my insurance company.

Cancellation:
We require 24 hours' notice if you need to cancel/change your appointment so that we may accommodate another client in need of our therapeutic services. If you cancel with less than 24 hours' notice, a $30.00 cancellation fee may be charged to your account and/or credit card. We hold encrypted credit card information on our secure server.

_____	_____	_____
Signature	Date	Technician Signature