

**Laser Therapy Intake Form**

**Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physical Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who May We Thank For Referring You?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Emergency Information**

**Person to contact in case of emergency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**🙢 🙠**

**Please tell us the reason for this laser session**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Does this cause you pain? 🞏 Yes 🞏No If yes, on a scale of 1 – 10, 10 being the worst pain ever. What is your pain scale number right now?\_\_\_\_**

**How long have you had this issue?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What have you done to try to resolve this issue?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Does this issue interfere with 🞏 work 🞏 sleep 🞏 school 🞏 eating 🞏 drinking 🞏 intimacy**

**🞏 other, please list** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you, in your lifetime, had any auto accidents, falls, head trauma, concussions or bodily injury? Please list what they are with the approximate date of injury:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please List All Current Medications and Supplements That You Are Taking:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Has your doctor told you to limit your exposure to the sun due to the medications that you are taking?** 🞏 Yes 🞏 No

**Please list all hospitalizations, surgeries, transplants that you have had:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please list all vaccinations that you have had:**

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**Do you have any dental implants, bridges, or silver/gold amalgam fillings** 🞏 Yes 🞏 No

**Do you have any silicone implants, titanium plates, screws, pins etc.?** 🞏 Yes 🞏 No

**Have you been diagnosed with any of the following:**

🞏Cancer 🞏Heart Condition 🞏 Bi-Polar 🞏 Depression 🞏 Anxiety 🞏 Hepatitis

🞏 Seizures 🞏 Stroke 🞏 Emphysema 🞏 Thyroid Condition 🞏 Ulcer 🞏 Migraines

🞏 Headaches 🞏 Neuropathy 🞏 Skin Condition(s) 🞏 Sinusitis 🞏 Arthritis 🞏 Asthma

🞏 Colitis 🞏 Diverticulitis 🞏 SIBO 🞏 Diabetes 🞏 Crohn’s 🞏 Gout

🞏 Lyme 🞏 Mold Poisoning 🞏 Alzheimer’s 🞏 Dementia 🞏 Erectile Dysfunction

🞏 Lung Condition 🞏 Bladder Disease 🞏 Kidney Disease 🞏 Chronic Fatigue Syndrome

🞏 Fibromyalgia 🞏 Polymyalgia 🞏 Burning Mouth Syndrome **🞏** Lung Issues

🞏 High Blood Pressure 🞏 Slow Wound Healing 🞏 Heavy Metal Poisoning

Any other diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you use essential oils topically? 🞏 Yes 🞏 No. If Yes, are the photosensitizing? Meaning, the oil(s) can not be exposed to the sun.



**Champion Chiropractic Center, Inc. Laser Therapy Informed Consent & Contraindication Form**

I hereby request and consent to the performance of Class IV Laser Therapy treatment by Dr. Steven Sandifer and/or his preceptor and/or other licensed doctors of chiropractic or a certified technician of Champion Chiropractic Center, Inc. who now or in the future treat me while employed by, working or associated with, or serving as a back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I understand that Class IV Laser Therapy treatments are a medical treatment that uses specific wavelengths of light to impart energy into injured cells and tissues. This energy is transformed from photon energy to biochemical energy in the cells which can then be used in the repair processes in the body. The expected direct outcomes from laser treatment may include reduced inflammation, reduced pain, and repair of tissues. The indirect outcomes may include increased ranges of motion, comfort and activity levels. Alternatives to Class IV Laser Therapy treatments include, but are not limited to chiropractic care, massage therapy, physical therapy, exercise therapy, anti-inflammatory or anti-pain medication, ultrasound, physiotherapy, mental health counseling, or drug therapy.

I have had an opportunity to discuss with the doctor named above and/or other office or clinic personnel the nature and purpose of the Class IV Laser Therapy treatments. I understand and am informed that, as in the practice of medicine, in the practice of Class IV Laser Therapy there are some risks to treatment including, but not limited to:

* **Short Term Effects**: I understand that there are multiple short-term effects that may occur, including reddening, irritated raised rash, mild burning, swelling, bruising, numbing, temporary pigmentary change, blistering, scabbing, crusting, flaking, & sensitivity to the sun. Although these effects typically resolve within several days, they may persist for several weeks and rarely, even longer. I understand that the degree of the side effects varies from person to person, and it may not be possible to predict how I will respond.
* **Possible permanent effects**: I understand that although most side effects are short term and resolve fairly quickly, some effects may be permanent. Scarring, changes in pigmentation and hair loss may be permanent.
* **Discomfort associated with procedure**: I understand that the laser functions by heating up the targeted area (blood vessels, pigmentation, etc.). This heating sensation is minimized by the use of cool towels, but some level of discomfort may be felt. The level of discomfort depends on the treatment being done, and varies from person to person. The stinging or sensation of heat is typically short but may persist for several hours after the procedure.
* **People excluded from therapy**: I understand that certain patients should not have laser treatment. This includes any patients who have open wounds, malignant skin tumors, patients who have certain diseases that makes them sensitive to light, patients currently on Accutane (Isotretinoin) or who have been on Accutane within the last 3 months, and in many cases, patients who have tattoos.
* **Need for multiple treatments**: I understand that some conditions being treated by the laser may require multiple treatments that may take 6 months to a year to obtain the desired results. Everyone responds in different ways and different rates to the treatment.
* **Tattoo/permanent makeup**: If there are any tattoos or permanent makeup in the area, there is a possibility of blistering and lightening of the tattoo/makeup.
* **Photographs or video**: I understand photos or video of my treatment may be taken. These may be used for teaching health professionals or shown for scientific reasons. I will NOT be identified in any photo or video without my informed consent.
* **I agree to wear proper eyewear**: Eye injury due to use of the laser is a risk to the patient and to the clinician; however, the risks are almost completely eliminated with the use of proper eyewear. I understand that Class IV Therapy Lasers emit both visible and invisible light. Protective eyewear is necessary at all times during the treatment. I will not remove the Safety Goggles until the administrator of the laser has turned off the laser treatment and provided notification that it is safe to remove them. You may be asked to remove reflective objects, such as rings, metal watchbands, cell phones, and jewelry prior to treatment with the laser.
* **I understand that this procedure is elective** and there are other options for treatment including no treatment.
* **I understand that medical insurance will NOT cover the cost of Class IV laser therapy**, and I am responsible for the complete cost of the service. Payment is due at the time of the treatment unless other arrangements have been made in advance.
* **I understand that the risks of not having laser treatments include, but are not limited to:** ongoing pain and inflammation development of scar tissue, development of degenerative changes, and reduction in daily activities and overall comfort.

**Contraindications To Class IV Laser Therapy**

Please answer to the best of your knowledge the following questions:

Are you pregnant? 🞏 Yes 🞏 No

Do you have cancer? 🞏 Yes 🞏 No

Have you had cancer within the past 12 months? 🞏 Yes 🞏 No

Are you currently taking any photosensitizing medications? 🞏 Yes 🞏 No

Are you currently using any photosensitizing essential oils? 🞏 Yes 🞏 No

If yes, can you be in the sun for 10 – 15 minutes without having itchiness, redness, blotchiness or pigmentation issues? 🞏 Yes 🞏 No

**Class IV Laser Therapy Precautions**

To the best of my knowledge, I may have one or more of the following:

Do you have a pacemaker or other implanted medical device (morphine pump, neurostimulator, etc.)? 🞏 Yes 🞏 No

Have you had steroid injection(s) within the past 7 days? 🞏 Yes 🞏 No

If yes, where on your body was the injection?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your pain directly over an epiphyseal plate (growth plate) in children under the age of 15 years old? 🞏 Yes 🞏 No

Is your pain over the Ovaries, Testes or Thyroid Gland? 🞏 Yes 🞏 No

I have read, or have had read to me, the Informed Consent To Class IV Laser Therapy treatment. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-name procedure. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Name Date

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Guardian Signature Date

Health Care Professional\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Professional Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**After Laser Treatment Care**

1. Increased soreness may occur after your first laser therapy treatment and sometimes the second and third treatments as well. This is a normal healing phenomenon known as **RETRACING.** If soreness occurs following your treatment, use ice on the area of soreness for 5 minutes every 30 minutes, and no more than 5 minutes every 30 minutes.

Repeat the icing as necessary. If soreness persists after icing, please contact us at

(360)438-6559.

1. Many times, after laser therapy, you feel wonderful! That’s great! But the areas of treatment are very vulnerable to reinjury. While you may feel much less pain, your body is still in the healing process. Please refrain from any exercise, long distance walking, running, jogging, heavy lifting, gardening, yard work, or any other strenuous work that could reverse the effects of the laser therapy. You are investing in your health, longevity and future. Give your body a break so the healing process can take place.
2. Do not use perfumed or medicated lotions or oils on your skin directly after laser therapy. This could cause rash, blistering, or burning of the skin. Wait at least one hour after your laser therapy to apply medicated or perfumed lotions unless you get approval from your technician.
3. Acute conditions less than 6 weeks old typically take 2-3 weeks for quality long term outcomes.

Chronic condition’s healing time vary depending on the condition. They can take as soon as 3 weeks up to 6 months for positive outcomes. Long term quality outcomes then are placed on maintenance phase.

1. Maintenance Phase: Chronic conditions managed by treatments are on as needed basis. The more you assist in a healthy lifestyle the faster you will recover and hold your laser treatments. As soon as symptoms arise it will take 1-2 sessions to return to maintenance. If you allow the symptoms to fully recur, you will need to start laser therapy over again.
2. If you have any questions or concerns at any time, please call Champion Chiropractic center at (360)438-6559 to discuss your questions or concerns with an available staff member.

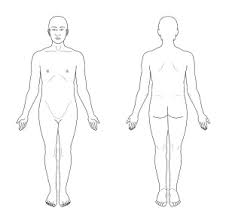
**Laser Therapy SOAP**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brief History Of Injury :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Goals For Treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_







**Complimentary Laser Treatment** Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Pain Scale Before Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ROM Before Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Area treated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Watts/Power: 🞏5\_\_\_\_\_\_🞏7\_\_\_\_\_\_\_\_🞏15\_\_\_\_\_\_\_\_🞏20\_\_\_\_\_\_🞏25\_\_\_\_\_\_\_\_🞏30\_\_\_\_\_\_\_🞏35\_\_\_\_\_\_\_\_\_

🞏Brain 1 🞏Brain 2

Time: 🞏2.5min \_\_\_\_\_\_\_\_\_\_ 🞏5min\_\_\_\_\_\_\_\_\_\_\_\_ 🞏7.5min\_\_\_\_\_\_\_ 🞏10min\_\_\_\_\_\_\_\_\_\_ 🞏15min\_\_\_\_\_\_\_\_\_\_

Pain Scale After Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ROM After Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan of Care: 🞏Care As Needed 🞏Daily for three days 🞏3 Times Per Week For \_\_\_\_\_\_\_\_\_\_\_ Weeks

🞏 Two Times Per Week For \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weeks 🞏One Time Per Week For \_\_\_\_\_\_\_\_\_\_\_\_ Weeks

🞏 Two Times Per Month 🞏 One Time Per Month

Technician Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Technician Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_ Laser Treatment** Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Pain Scale Before Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ROM Before Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Area treated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Watts/Power: 🞏5\_\_\_\_\_\_🞏7\_\_\_\_\_\_\_\_🞏15\_\_\_\_\_\_\_\_🞏20\_\_\_\_\_\_🞏25\_\_\_\_\_\_\_\_🞏30\_\_\_\_\_\_\_🞏35\_\_\_\_\_\_\_\_\_

🞏Brain 1 🞏Brain 2

Time: 🞏2.5min \_\_\_\_\_\_\_\_\_\_ 🞏5min\_\_\_\_\_\_\_\_\_\_\_\_ 🞏7.5min\_\_\_\_\_\_\_ 🞏10min\_\_\_\_\_\_\_\_\_\_ 🞏15min\_\_\_\_\_\_\_\_\_\_

Pain Scale After Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ROM After Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan of Care: 🞏Care As Needed 🞏Daily for three days 🞏3 Times Per Week For \_\_\_\_\_\_\_\_\_\_\_ Weeks

🞏 Two Times Per Week For \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weeks 🞏One Time Per Week For \_\_\_\_\_\_\_\_\_\_\_\_ Weeks

🞏 Two Times Per Month 🞏 One Time Per Month

Technician Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**\_\_\_\_\_\_\_\_Laser Treatment** Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Pain Scale Before Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ROM Before Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Area treated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Watts/Power: 🞏5\_\_\_\_\_\_🞏7\_\_\_\_\_\_\_\_🞏15\_\_\_\_\_\_\_\_🞏20\_\_\_\_\_\_🞏25\_\_\_\_\_\_\_\_🞏30\_\_\_\_\_\_\_🞏35\_\_\_\_\_\_\_\_\_

🞏Brain 1 🞏Brain 2

Time: 🞏2.5min \_\_\_\_\_\_\_\_\_\_ 🞏5min\_\_\_\_\_\_\_\_\_\_\_\_ 🞏7.5min\_\_\_\_\_\_\_ 🞏10min\_\_\_\_\_\_\_\_\_\_ 🞏15min\_\_\_\_\_\_\_\_\_\_

Pain Scale After Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ROM After Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan of Care: 🞏Care As Needed 🞏Daily for three days 🞏3 Times Per Week For \_\_\_\_\_\_\_\_\_\_\_ Weeks

🞏 Two Times Per Week For \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weeks 🞏One Time Per Week For \_\_\_\_\_\_\_\_\_\_\_\_ Weeks

🞏 Two Times Per Month 🞏 One Time Per Month

Technician Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**\_\_\_\_\_\_ Laser Treatment** Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Pain Scale Before Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ROM Before Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Area treated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Watts/Power: 🞏5\_\_\_\_\_\_🞏7\_\_\_\_\_\_\_\_🞏15\_\_\_\_\_\_\_\_🞏20\_\_\_\_\_\_🞏25\_\_\_\_\_\_\_\_🞏30\_\_\_\_\_\_\_🞏35\_\_\_\_\_\_\_\_\_

🞏Brain 1 🞏Brain 2

Time: 🞏2.5min \_\_\_\_\_\_\_\_\_\_ 🞏5min\_\_\_\_\_\_\_\_\_\_\_\_ 🞏7.5min\_\_\_\_\_\_\_ 🞏10min\_\_\_\_\_\_\_\_\_\_ 🞏15min\_\_\_\_\_\_\_\_\_\_

Pain Scale After Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ROM After Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan of Care: 🞏Care As Needed 🞏Daily for three days 🞏3 Times Per Week For \_\_\_\_\_\_\_\_\_\_\_ Weeks

🞏 Two Times Per Week For \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weeks 🞏One Time Per Week For \_\_\_\_\_\_\_\_\_\_\_\_ Weeks

🞏 Two Times Per Month 🞏 One Time Per Month

Technician Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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