Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information requested. Please note that all information provided below will be kept confidential. Your written permission will be required to release any information.

Name: _____ **Phone #** _____

Address:_____

Occupation _____ **Date of Birth**_____

Have you received laser therapy before? **Yes❒** **No ❒**

Did a health practitioner refer you for laser therapy? **Yes❒** **No❒**
If yes, please provide their name & address_____

_____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
❒high blood pressure
❒low blood pressure
❒congestive heart failure
❒heart attack
❒varicose veins/phlebitis
❒stroke/CVA
❒pacemaker
❒heart disease
is there a family history of any of the above?
❒Yes ❒No

Respiratory
❒chronic cough
❒shortness of breath
❒bronchitis
❒asthma
❒emphysema
❒skin conditions, what?+

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

Infections
❒hepatitis
❒skin conditions
❒TB
❒HIV
❒herpes

Other Conditions
❒loss of sensation…
Where?_____
_____
❒epilepsy
❒cancer…where?____
_____
❒diabetes
❒allergies,
hypersensitivity to what?
_____
_____
❒arthritis

is there a family history of arthritis? ❒Yes ❒No

Head/Neck
❒history of headaches
❒history of migraines
❒vision problems
❒vision loss
❒ear problems
❒hearing loss

Women
❒pregnant
❒gynecological conditions…what?
_____

Overall, how is your general health?
_____

Primary Care Physician:
Name & Address_____
_____
_____
_____

Do you have any other medical conditions? (e.g. digestive conditions, hemophilia, osteoporosis, mental illness) ❒Yes ❒No

Do you have any internal pins, wires, artificial joints or special equipment? ❒Yes ❒No

What? _____

Where? _____

What is the reason you are seeking laser therapy?
Please include the location of any tissue or joint discomfort or pain.

_____

_____

_____

What is your email address? (We will use this for follow up purposes.)

_____

Office use only

Date of initial Health History _____

Update 1 _____

Update 2 _____

Update 3 _____