

### 111 SOUTH HUDSON AVE PASADENA, CA 91101 Phone (626) 683 - 8536 Fax (626) 683 - 8236

www.EvergreenPT.net

#### PATIENT REGISTRATION

Patient's Name		Date of Birth/	
Guardian (If minor)	Relationship		
Patient's Address			
City	State	Zip	
Cell Phone	Home Phone		
Email Address			
I would like to receive appointment reminders	via 🗌 Email 🔲 Te	xt or ☐ Phone Call	
Emergency Contact	Phone		
Relationship to Patient			
Referring Physician		Phone	
Diagnosis			
Date of Injury / Onset / Surgery:	<del> </del>		
Was This Related to an Accident? Auto/ V	Vork / Other Dat	e of Accident	
Have you had prior Physical Therapy, Occupa Yes / No If yes, how many visits?	• • •	• •	
Are you currently, or have you received Hom are not limited to nurse, physical therapy, administration. Yes / No		· · · · ·	
If yes, have you been discharged? Yes /	No Date of Disc	harge	
* Please note that if you have Medicare an	nd are currently re	eceiving Home Health services, you may	

not begin outpatient physical therapy without first being discharged from Home Health.

## **Informed Consent**

Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. Laser therapy utilizes visible and invisible laser radiation, therefore, appropriate eye protection is required at all times during treatment.

Effects of your treatment will continue for up to 18 hours. Individuals respond uniquely to treatment, you may see immediate results after the first treatment or depending on the severity of your condition, you may require several treatments before you begin to feel results.

Increased soreness may occur after your first laser session. This is a normal healing phenomenon known as retracing. Mild bruising may occur from the soft tissue manual therapy element of your treatment program.

You are required to complete the Patient Intake Form prior to treatment to ensure that laser therapy is a viable option for you.

Ц	i understand the above and consent to treatment				
	I understand that failing to complete any part of my treatment program will reduce my chances of success.				
	Patient Signature	Date			
	Print Patient Name	Date			



#### LASER MEDICAL HISTORY

Patient Name: (Print)				Date:	
Medical History: Are you cu				following:	
High Blood Pressure		The same of the sa	YN	Numbness	YN
Bowel/Bladder Problems		Pacemaker	YN	Cancer	YN
Shortness of Breath	YN		YN	Pregnant	YN
Blood Clots	YN	Diabetes	YN	Dizziness	YN
Night Pain	YN	Fatigue	YN	Osteoporosis	YN
Irregular Heart Rate		Headaches	YN	Stroke	YN
Are you taking any blood thi					YN
Do you have very light sensi		osensitive)? Y N			
Do you currently have any ir					
Do you have Kidney disease					
Are you taking any of the fol		ations (please circle)			
				rth control) Phoonothios	rines Deorelans
Antihistamine, Coal tar a					
Corticosteroids, Cortisone St					ies,
Tricyclic Antidepressants, H					
Recent Surgeries? Y N (	List)				
Do you have any tattoos? Y	N				
List other medical problems:	ji				
Currently:					
What is your current con	nplaint?			When did it start?	
What is your current con Due to an injury? Y N ( Did the symptoms begin	Explain)			Illness?	
Did the symptoms begin	: Suddenly or	Gradually	Previous pro	oblems in this area? Y N	
Previous therapy for this	condition? Y	N What effect?	rio de pro		
Trovious morapy for time	Condition: 1				
Are you getting: Better	Same Wors	e Are you better y	with rest? Y	N	
Does activity make you	worse? V N	Which activitie	200	11	
What reduces your pain? What can't you do becau					
what can't you do becat	ise of your syn	nptoms?			
What did the Doctor tell	you is your di	agnosis?			
Based upon a 0 to 10 sca					
Right now: H	Highest pain in	past 24 hours:	Low	est pain in past 24 hours:	:
PLEASE COMPLETE AF	REAS OF PAI	N ON THE BODY	<b>DIAGRAM</b>	BELOW:	
R FRONT L	L F	BACK R			
tooth		( )			
jaw	shoulder	neck/shoulder			
	stroutes	pper back			
etbo		<b>A</b>			
abdomen		ower back			
wrist hip	1/1				
Full I	3 8				
100	100 YU	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			
	leg				
knee	),				
	ankle				
of foot O		O	SIGN	ATURE	
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Date:\_



# Laser Therapy

Get back to the activities you love with advanced technology of Laser PAIN RELIEF \* DRUG-FREE \* SURGERY FREE

#### **Package**

1 Evaluation (non-patient)	\$ 80
1 Single Treatment	\$ 65
3 Treatments	\$ 180
5 Treatments	\$ 280
10 Treatments	\$ 480
20 Treatments	\$ 900

Free consultation for current patients receiving physical therapy.

Give yourself the gift of less pain w/ Class 4 Laser, proven effective in treatment of:

- Sprains and Strains
- Low Back Pain
- Sports Injuries
- Joint Pain
- Neck Pain
- Fibromyalgia

- Tendinitis
- Plantar Fasciitis
- Headaches
- Post-Surgical / Incision Pain
- Inflammation

- Arthritis Pain
- Hip / SIJ pain
- Sciatica
- Neuropathies
- Soft Tissue Injury
- Wrist/ Hand Pain

## Why Laser Therapy?

Deep Tissue Laser Therapy is an FDA approved, advanced therapeutic technology that speeds up your healing and improves results. It reduces inflammation and swelling, which results in pain reduction. Laser Therapy is effective in treating new injuries, chronic conditions and post-surgical pain. It can enhance your recovery and speed up treatment outcomes.

Treatments immediately feel good. Laser therapy treatments are safe, painless and fast and are customized for each situation. The applicator allows us to do soft tissue work while delivering energy. One treatment typically lasts 5-10 minutes.

Laser Therapy utilizes your body's own healing powers by stimulating cellular activity. Despite fast treatment times, laser therapy treatments initiate a healing process that continues to actively reduce inflammation for up to 24 hours after treatment.

Form Modified on 11/17/2023