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**Case History**  
**MLS® Laser Therapy**

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
E-mail address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M or F  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Years Employed: \_\_\_\_\_  
Is this condition employment related? Y/N Accident Related? Y/N Martial Status: M S W D  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Who referred you for MLS Laser Therapy: \_\_\_\_\_  
How did you hear about MLS Therapy: \_\_\_\_\_

**What is your major complaint?** \_\_\_\_\_  
\_\_\_\_\_

Other complaints? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Have you had this or similar conditions in the past? Y/N, explain: \_\_\_\_\_

What activities aggravate your condition? \_\_\_\_\_

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily Routine Other: \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

**Other Doctors seen for this Condition:** MD DC DO DDS DPM

Doctor's name: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

X-rays: \_\_\_\_\_ Urinalysis: \_\_\_\_\_ Blood Tests: \_\_\_\_\_ Other: \_\_\_\_\_

Treatment: Medication: \_\_\_\_\_ Physiotherapy: \_\_\_\_\_

Results: \_\_\_\_\_ Length of time under care: \_\_\_\_\_

Please list ALL surgeries within the last year: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been involved in an auto accident? Y/N, explain: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been involved in any other accidents? Y/N, explain: \_\_\_\_\_  
\_\_\_\_\_

Have you ever had any broken bones? Y/N, explain: \_\_\_\_\_  
\_\_\_\_\_

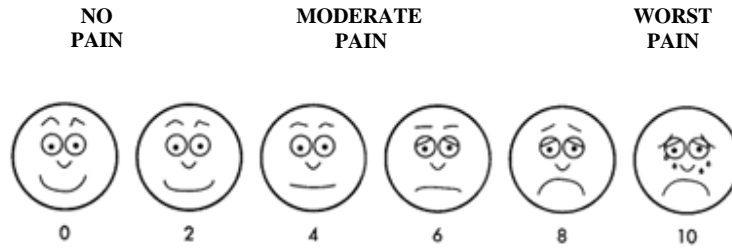
Have you ever been diagnosed with cancer? Y/N, explain: \_\_\_\_\_

Do you have an implanted neurostimulator device? Y/N, where: \_\_\_\_\_

Do you have a pacemaker? Y/N \_\_\_\_\_

Are you currently taking any medications/supplements? Y/N, explain: \_\_\_\_\_

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

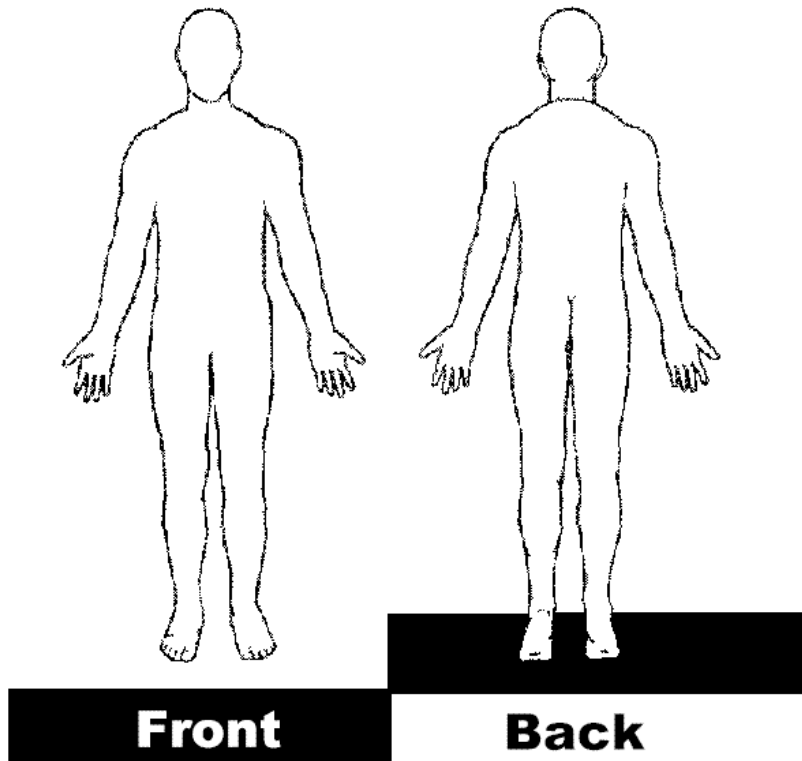


**Use this chart to estimate your pain level (Circle One).**

Please check any of the following that apply to you:

- |   |  |
|---|--|
| <input type="checkbox"/> Take medication that increases sensitivity to sunlight | <input type="checkbox"/> Take blood thinners       |
| <input type="checkbox"/> Have a seizure disorder that is triggered by light     | <input type="checkbox"/> Are pregnant              |
| <input type="checkbox"/> Have hemorrhagic diatheses                             | <input type="checkbox"/> Have HIV positive history |
| <input type="checkbox"/> Been injected with steroids in the past 2-3 weeks      | <input type="checkbox"/> Spinal Surgery            |
| <input type="checkbox"/> Leukemia   |  |

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**Please x any area of pain**



Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Doctor's Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_