Regenerative Therapy Intake Form & Medical Clearance

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | | Today's Date: | | | |  |
| Date of Birth: | | | Age: | Male Female | | | | |
| Address: |  | | | | | | | |
| City: | State: | | | | Zip: | | | |
| Home Phone: | Cell Phone: | | | Email: | | | | |
| Best way to contact you: Call Home Call Cell Text Cell Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email | | | | | | | | |
| Parent Name (If Minor): | | | | | | Phone Number: | | |
| Referral Information | | | | | | | | |
| How did you hear about our office? | | | | | | | | |
| Emergency Information | | | | | | | | |
| Emergency Contact: | | | | | | | | |
| Phone: | | Relationship: | | | | | | |
| Reason(s) For Seeking Laser Treatment | | | | | | | | |
| What are you hoping we can help with? (Describe and Circle Areas Involved)    C:\Users\Dell\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\HECQCK6J\20071116234908!Outline-body-aura[1].pngC:\Users\Dell\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\HECQCK6J\20071116234908!Outline-body-aura[1].png Front Back | | | | | | | | |
| Please answer ***ALL*** of the following: | | | | | | | | |
| Are you taking any anticoagulants? | | | | | | | Yes No | |
| Are you taking any medication that is known to increase sensitivity to sunlight? | | | | | | | Yes No | |
| Do you have a known sensitivity to MLS Laser? | | | | | | | Yes No | |
| Do you have a seizure disorder triggered by light? | | | | | | | Yes No | |
| Are you or could you be pregnant? | | | | | | | Yes No | |
| Are you aware of carrying any sort of infectious disease? | | | | | | | Yes No | |
| If Yes, Please Describe: | | | | | | | | |
| Do you have an HIV Positive History? | | | | | | | Yes No | |
| Do you have areas of suspicious, potential, or known cancerous tissue? | | | | | | | Yes No | |
| If Yes, Please list areas: | | | | | | |  | |
| Do you have areas of active hemorrhage? | | | | | | | Yes No | |
| Have you had a steroid injection in the last 2-3 weeks? | | | | | | | Yes No | |
| Do you have a pacemaker? | | | | | | | Yes No | |
| Are there any areas of your body where you have no feeling? | | | | | | | Yes No | |
| Have you ever had a laminectomy? | | | | | | | Yes No | |
| Do you have an implanted neurostimulation device (on ***OR*** off)? | | | | | | | Yes No | |
| Do you have tattoos? | | | | | | | Yes No | |
| If yes, over what body areas? | | | | | | | | |

|  |  |
| --- | --- |
| **Please Initial after each of the following:** | |
| I understand that Regenerative Therapy is a non-covered service by insurance companies. |  |
| I understand that my insurance company will not be billed and I cannot bill my insurance company for Regenerative Therapy. |  |
| I understand that payments & packages for Regenerative Therapy are separate from any chiropractic accounts. |  |
| Regenerative Therapy Packages carry individual costs since care is completely customized. Before committing to treatment, all costs will be discussed with you & agreed upon between the provider and patient. |  |
| We request 24 Hours’ notice for rescheduling or cancelling appointments.  There is a $150 fee for a No Call/No Show Missed Appointments. |  |

Affirmation & Consent for Laser Treatment

I affirm that all of the information I have provided to Pro Health Chiropractic, S.C. is accurate and up to date.

***Once Medically Cleared:***

I understand that Regenerative Therapy is not effective in 100% of patients.

I will be educated on Regenerative Therapy on my specific complaint and I consent to treatment by Pro Health Chiropractic.

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Signature Date