



EVERGREEN PHYSICAL THERAPY SPECIALISTS, INC.  
200 E. DEL MAR BLVD. SUITE 302, PASADENA, CA 91105

### PATIENT REGISTRATION FORM

PATIENT'S NAME \_\_\_\_\_

GUARDIAN (IF MINOR) \_\_\_\_\_

PATIENT'S ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

SSN# \_\_\_\_\_ CDL# \_\_\_\_\_

SEX: MALE FEMALE MARITAL STATUS: S M D W

**IN CASE OF EMERGENCY** \_\_\_\_\_ **PHONE** \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_ DATE OF LAST VISIT \_\_\_\_\_

DATE OF INJURY/ONSET/SURGERY: \_\_\_\_\_

ACCIDENT: AUTO WORK OTHER DATE OF ACCIDENT: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

ADJUSTOR: \_\_\_\_\_ PHONE \_\_\_\_\_

HAVE YOU HAD PT, OT, SPEECH, CHIRO, ACCUPUNCTURE THIS YEAR? YES NO  
HOW MANY VISITS? \_\_\_\_\_

**LASER MEDICAL HISTORY**

**Patient Name: (Print)** \_\_\_\_\_

**Date:** \_\_\_\_\_

Medical History: Are you currently experiencing or have you had any of the following:

High Blood Pressure	Y N	Heart Disease	Y N	Numbness	Y N
Bowel/Bladder Problems	Y N	Pacemaker	Y N	Cancer	Y N
Shortness of Breath	Y N	Weakness	Y N	Pregnant	Y N
Blood Clots	Y N	Diabetes	Y N	Dizziness	Y N
Night Pain	Y N	Fatigue	Y N	Osteoporosis	Y N
Irregular Heart Rate	Y N	Headaches	Y N	Stroke	Y N
				Pelvic Issues	Y N

Are you taking any blood thinners? Y N  
 Do you have very light sensitive skin (photosensitive)? Y N  
 Do you currently have any infections/fever? Y N  
 Do you have Kidney disease? Y N

Are you taking any of the following Medications (please circle):

Antihistamine, Coal tar and derivatives, Antifungals, Contraceptives (birth control), Pheonothiazines, Psoralens, Corticosteroids, Cortisone Sulfonamides, Sulfonyleureas, Thiazide Diuretics (water pills), Tetracyclines, Tricyclic Antidepressants, High-dose Vitamin A (ie. Accutane), Immunosuppressant drugs

Recent Surgeries? Y N (List) \_\_\_\_\_

Do you have any tattoos? Y N

List other medical problems: \_\_\_\_\_

Currently:

What is your current complaint? \_\_\_\_\_ When did it start? \_\_\_\_\_

Due to an injury? Y N (Explain) \_\_\_\_\_ Illness? \_\_\_\_\_

Did the symptoms begin: Suddenly or Gradually \_\_\_\_\_ Previous problems in this area? Y N

Previous therapy for this condition? Y N What effect? \_\_\_\_\_

Are you getting: Better Same Worse Are you better with rest? Y N

Does activity make you worse? Y N Which activities? \_\_\_\_\_

What reduces your pain? \_\_\_\_\_

What can't you do because of your symptoms? \_\_\_\_\_

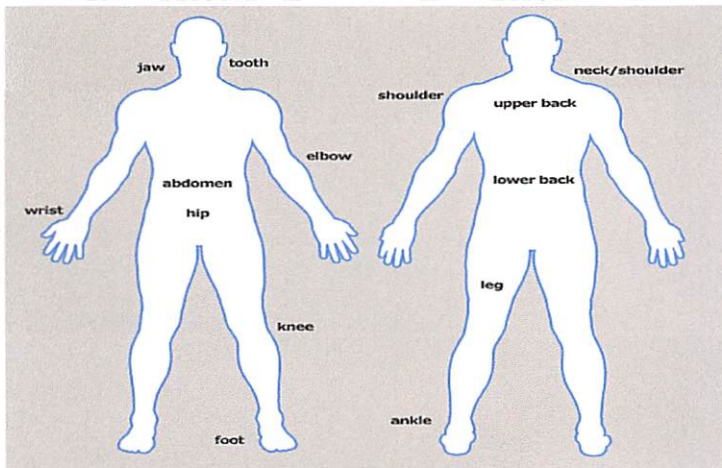
What did the Doctor tell you is your diagnosis? \_\_\_\_\_

Based on a 0 to 10 scale (0 is none and 10 is severe), what is your pain:

Right now: \_\_\_\_\_ Highest pain in past 24 hours: \_\_\_\_\_ Lowest pain in past 24 hours: \_\_\_\_\_

**PLEASE COMPLETE AREAS OF PAIN ON THE BODY DIAGRAM BELOW:**

**R FRONT L L BACK R**



**SIGNATURE** \_\_\_\_\_

Date: \_\_\_\_\_

# 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.

- 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.

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Patient Signature  
Date

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Print Patient Name  
Physician Signature



# EVERGREEN

PHYSICAL THERAPY SPECIALISTS

## Laser Therapy

~Get back to the activities you love with advanced technology of Laser ~

PAIN RELIEF \* DRUG-FREE \* SURGERY FREE

### Package

1 First Consult w/ Laser	\$ 80
3 Treatments	\$ 180
5 Treatments	\$ 280
10 Treatments	\$ 480 (get one free - 11 treatments )

*First time fee waived for current patients who have a plan of care.*

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.