

Treatment Consent Form

Date 2/28/04

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name Theresa Collins Age 49 Gender F

Street Address 2295 W. Liddell Rd

City Duluth State GA Zip 30076

Email TheresaCollins@hotmail.com Phone (770) 8490523

- 1. Where is your pain? right arm
- 2. What caused it? repeated movement @ pre-K school
- 3. Approximately when did it start? 1 year
- 4. Is it getting worse, better or staying the same? staying the same
- 5. What activity(s) does it interfere with? picking up items, reaching for items
- 6. What is your pain right now? (circle #)
0...1...2...**3**...4...5...6...7...8...9...10
Mild Moderate Severe/Agony

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Patient (or Parent) Signature Theresa Collins

Witnessed by _____

(Patient Completes after Treatment)
Please describe your experience with laser treatment.
Reduced aching in elbow area when extended.

(For Office Use Only)
Pre-treatment sign:

Pre-treatment Pain level:

RESULTS:
1/10

Treatment remarks:

Treatment Provided by:

Treatment Consent Form

Date 1.2.08

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name ROBERT A BONIKAS Age 78 Gender M

Street Address 17711 COLLIE

City NB State GA Zip 92647

Email _____ Phone (704) 8425010

1. Where is your pain? LEG
2. What caused it? ?
3. Approximately when did it start? 3 wks
4. Is it getting worse, better or staying the same? SAME
5. What activity(s) does it interfere with? WALKING
6. What is your pain right now? (circle #) 0...1...2...3...4...5...**6**...7...8...9...10
Mild Moderate Severe/Agony

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Patient Signature [Signature]

Witnessed by [Signature]

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

Everything that I complained about is gone. I feel a lot better. From a 6 to a 1. I feel a little pain.

(For Office Use Only)

Pre-treatment sign:

Pre-treatment Pain level:

RESULTS:

1/10

Treatment remarks:

Treatment Provided by:

Treatment Consent Form

Date 1/3/2005

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name Rob Adams Age 50 Gender M

Street Address 2430 E. Hwy 153

City Beaverton State UT Zip 84713

Email rga@cinusolutions.com Phone (435) 438-1716

- 1. Where is your pain? Left Shoulder
2. What caused it? Unsuic - 6 month chronic pain
3. Approximately when did it start? May/June 2004
4. Is it getting worse, better or staying the same? Staying the same
5. What activity(s) does it interfere with?
6. What is your pain right now? (circle #) 6

When I extend

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Patient (or Parent) Signature [Signature]

Witnessed by

(Patient Completes after Treatment) Please describe your experience with laser treatment. I felt nothing during treatment. After treatment, my shoulder feels somewhat different pain is definitely less than before. I am waiting to see what I will feel like in the morning. A positive experience overall!

(For Office Use Only) Pre-treatment sign: Pre-treatment Pain level: RESULTS:

Treatment remarks:

Treatment Provided by:

Treatment Consent Form

Date 1/3/2005

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name Esther Bonillas Age 80 Gender F
Street Address 19711 Callie Ln
City Huntington Beach Ca State Ca Zip 92647
Email _____ Phone (714) 842-5010

1. Where is your pain? Back
2. What caused it? ?
3. Approximately when did it start? 1 year ago
4. Is it getting worse, better or staying the same? same
5. What activity(s) does it interfere with? Walking
6. What is your pain right now? (circle #)
0...1...2...3...4...5...6...7...8...9...10
Mild Moderate Severe/Agony

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Patient Signature Esther Bonillas Witnessed by [Signature]

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

2/10 - Feels almost no pain. Better than when she got it the first time.

Treatment remarks:

(For Office Use Only)

Pre-treatment sign:

Pre-treatment Pain level:

5/10
RESULTS:
2/10

Treatment Provided by: maggie

Treatment Consent Form

Date 1-2-05

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name Geni Gonzalez Age 57 Gender F
 Street Address 18962 Holly Way
 City Carone State CA Zip 92881
 Email _____ Phone (951) 273-7902

1. Where is your pain? Bone Spine (heels)
2. What caused it? _____
3. Approximately when did it start? 2-3 years ago
4. Is it getting worse, better or staying the same? better since treatment
5. What activity(s) does it interfere with? walking
6. What is your pain right now? (circle #)
 0...1...2...3...4...5...6...7...8...9...10
 Mild Moderate Severe/Agony

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Patient Signature Geni Gonzalez Witnessed by Carbo

(Patient Completes after Treatment)
 Please describe your experience with laser treatment.
Felt less pain in both feet. Could feel throbbing in one or two places on each foot as it was treated. Considerable less pain after treatment. Able to walk with very little pain.

(For Office Use Only)
 Pre-treatment sign: pain & sustained sitting > 35 min.
pain increases to 8/10 & stretches
 Pre-treatment Pain level:
(L) heel = 4/10
(R) heel = 6/10
RESULTS:
(L) heel = 1/10
(R) heel = 2/10

Treatment remarks:
 4 J to B Achilles Tendon & attachment to calcaneus (medial, middle, lateral & also 4 J to inferior medial calcaneus (B)
 ~ 20 minutes total. Both / heel.

Treatment Provided by:
Carbo Y. Romero MPT

Treatment Consent Form

Date 1/3/05

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name Jose Avina Age 42 Gender Male
Street Address 3581 Raven st.
City Lake Elsinore State Ca Zip 92530
Email _____ Phone (951) 679-3973

1. Where is your pain? 1 back
2. What caused it? He lifted heavy things
3. Approximately when did it start? 10/22/03
4. Is it getting worse, better or staying the same? worsening
5. What activity(s) does it interfere with? sleep, sitting
6. What is your pain right now? (circle #)
0...1...2...3...4...5...6...7...**8**...9...10
Mild Moderate Severe/Agony

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Patient Signature [Signature] Witnessed by _____

(Patient Completes after Treatment)
Please describe your experience with laser treatment.
It helped me a lot
I feel a lot better.
The pain went from
an 8 ~~to a 10~~ to a 4.

4/10

(For Office Use Only)
Pre-treatment sign: _____
Pre-treatment Pain level: _____
RESULTS:
4/10

Treatment remarks:

Treatment Provided by:

Treatment Consent Form

Date 1/3/04

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name MARY CANZONE Age 67 Gender F

Street Address 37205 Wild Rose Ln.

City Murrieta State CA Zip 92562

Email Mickbill@earthlink.net Phone (951) 696-1763

1. Where is your pain? lower back - RT side.
2. What caused it? _____
3. Approximately when did it start? 1 yr ago
4. Is it getting worse, better or staying the same? SAME.
5. What activity(s) does it interfere with? most things
6. What is your pain right now? (circle #) 0...1...2...3...4...5...6...7...8...9...10
Mild Moderate Severe/Agony

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Patient Signature Mary Canzone Witnessed by _____

(Patient Completes after Treatment)
Please describe your experience with laser treatment.
7-8/10 pain @ SI region / gluteal
PT, PT
I do feel relief after the
treatment. I will try other
treatments along with my PT.

(For Office Use Only)
Pre-treatment sign:
pain & palpation
Pre-treatment Pain level:
7-8/10
RESULTS:
4-5/10 post tx
↓ d tenderness to
palpation

Treatment remarks:

Treatment Provided by: Gina Paine, PT

Treatment Consent Form

Date 1/3/05

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name Justyn Snell Age 15 Gender F
Street Address 40454 Calle Katherine
City Temecula State CA Zip 92591
Email _____ Phone () 699-3127

- 1. Where is your pain? right knee
- 2. What caused it? Soccer injury - ACL surgery
- 3. Approximately when did it start? April 1st
- 4. Is it getting worse, better or staying the same? getting worse
- 5. What activity(s) does it interfere with? competitive sports
- 6. What is your pain right now? (circle #) 2

0	1	2	3	4	5	6	7	8	9	10
		Mild			Moderate					Severe/Agony

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Patient (or Parent) Signature Julie C. Snell Witnessed by _____

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

My knee feels more relaxed, and I am able to bend it more, with less pain

(For Office Use Only)

Pre-treatment sign: _____

Pre-treatment Pain level: _____

RESULTS:

Treatment remarks:

Treatment Provided by:

Treatment Consent Form

Date 12/28/04

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name TOMAS W. BRAGANZA Age 84 Gender M
Street Address 9191 Florence
City Downey State Cal Zip _____
Email _____ Phone () _____

1. Where is your pain? BACK - SHOULDERS - FEET
2. What caused it? PUTTING UP CHRISTMAS DECOR
3. Approximately when did it start? 4 days before Christmas
4. Is it getting worse, better or staying the same? same
5. What activity(s) does it interfere with? walking
6. What is your pain right now? (circle #) 0...1...2...3...4...(5)...6...7...(8)...9...10
Mild Moderate Severe/Agony

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Patient (or Parent) Signature Tomas W. Braganza Witnessed by _____

(Patient Completes after Treatment)
Please describe your experience with laser treatment.
Felt big difference right away.
My pain had decrease significantly.

(For Office Use Only)
Pre-treatment sign: 7/10
Pre-treatment Pain level:
RESULTS:
2/10

Treatment remarks:

Treatment Provided by:

Treatment Consent Form

Date 12-28-04

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name GENEROSO C. SISON Age 67 Gender M

Street Address 10726 CLARIDGE PL.

City WHITTIER State CA Zip 90603

Email _____ Phone (562) 943-7939

- 1. Where is your pain? RT. SHOULDER + AROUND WAIST
- 2. What caused it? _____
- 3. Approximately when did it start? 1 YR. AGO + 10 YRS AGO
- 4. Is it getting worse, better or staying the same? SAME
- 5. What activity(s) does it interfere with? RAISING RT. HAND + BENDING DOWN
- 6. What is your pain right now? (circle #) 0...1...2...3...4...**5**...6...7...8...9...10
Mild Moderate Severe/Agony

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Patient (or Parent) Signature Generoso C. Sison

Witnessed by _____

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

After the treatment the pain on my RT. shoulder diminished.

(For Office Use Only)

Pre-treatment sign: _____

Pre-treatment Pain level: _____

RESULTS:

↑ motion

↓ Pain 1/10

Treatment remarks:

Treatment Provided by:

Treatment Consent Form

Date 1-4-05

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name Lilia Palagonas Age 59 Gender F Email _____

Street Address 5286 Orange Ave. City Long Beach

State CA Zip 90805 Phone (562) 422-0291 Occupation _____

1. Where is your **MOST** painful area? neck to shoulder, back

2. What caused it? _____

3. Approximately when did it start? long time

4. What activity(s) does it interfere with? _____

5. What is your pain right now? (circle #) 0...1...2...3...4...5...6...7... **8**...9...10
Mild Moderate Severe/Agony

6. What other types of treatment have you already received for this problem? pain killer Tablets

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Patient (or Parent) Signature L. Palagonas Witnessed by _____

(Patient Completes after Treatment)

Please describe your experience with the 830Laser treatment.

Pain went down to 0

How did you hear about us?

Treatment remarks:

Treatment Provided by:

Treatment Consent Form

Date 01/03/05

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name Buddie Carson Age 74 Gender M
Street Address 30091 Iron Horse Dr.
City Murrieta State Ca Zip 92563
Email _____ Phone (951) 894-4649

1. Where is your pain? lower back
2. What caused it? Chronic
3. Approximately when did it start? _____
4. Is it getting worse, better or staying the same? better
5. What activity(s) does it interfere with? everything
6. What is your pain right now? (circle #) 2
0...1...2...3...4...5...6...7...8...9...10
Mild Moderate Severe/Agony

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Patient Signature Buddie L. Carson Witnessed by _____

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

The treatment was very soothing & comfortable. I could feel the warmth from the laser. It helped the middle of my back & eased the pain -

(For Office Use Only)

Pre-treatment sign: _____

Pre-treatment Pain level: 2/10

RESULTS:

relief of central pain
1 spot remains 10/10

Treatment remarks:

Treatment Provided by: Maggie

Treatment Consent Form

Date 01/03/05

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name JOHN JOHNSON Age 45 Gender M

Street Address 39926 CNRAN CT.

City TIBURON State CA Zip 94920

Email j.johnson14@adelphia.net Phone (760) 802-0417

- Where is your pain? (4) index finger
- What caused it? brake
- Approximately when did it start? 10 weeks ago
- Is it getting worse, better or staying the same? better slowly
- What activity(s) does it interfere with? _____
- What is your pain right now? (circle #) 3
0...1...2...3...4...5...6...7...8...9...10
Mild Moderate Severe/Agony

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Patient Signature J. Johnson

Witnessed by _____

(Patient Completes after Treatment)
Please describe your experience with laser treatment.
Pain level is lower when exercising joint flexibility increased noticeably -

(For Office Use Only)
Pre-treatment sign:
Pre-treatment Pain level:
RESULTS:
1/10

Treatment remarks:

Treatment Provided by: