Dr. Shawn McDermott D/B/A/ Vermont Laser Chiropractic and the New England Laser Institute
85 N. Main St., Suite 230 White River Junction, VT 05001 (802) 295-9583

LASER INTAKE AND WAIVER

NAME: _____ M/F DOB: _____ AGE: _____

ADDRESS: _____

CELL: _____ HOME: _____ WORK: _____

I, the undersigned, understand and consent to low level laser therapy (LLLT) knowing the contraindications of: no laser beam into the eyes, and no treatment over a fetus or pregnancy. I acknowledge that there are no known complications with LLLT and cancer. I hold harmless those prescribing and administering the laser from any and all complications known or unknown, past, present or future. I hereby give my informed consent to proceed with LLLT. SIGNED: _____ DATE: _____

CHIEF/MAIN COMPLAINT: _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

PAIN SCALE: 10 is the worst pain you've ever had in your life; 0 is nothing; and 5 is halfway to your worst pain.

WHAT IS YOUR PEAK PAIN LEVEL? _____ (the worst pain since onset that you've ever had for this problem)
WHAT IS YOUR MOST RECENT PEAK PAIN LEVEL? _____ ("It was 6/10 three weeks ago", for example)

SECONDARY COMPLAINT: _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHAT IS YOUR PEAK PAIN LEVEL? _____

TERTIARY COMPLAINT: _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHAT IS YOUR PEAK PAIN LEVEL? _____
WHAT IS YOUR MOST RECENT PEAK PAIN LEVEL? _____

Chief complaint post _____ visit	Secondary complaint post _____ visit	Tertiary complaint post _____ visit
pain levels: _____	pain levels: _____	pain levels: _____
3 month pain levels: _____	3 month pain levels: _____	3 month pain levels: _____
6 month pain levels: _____	6 month pain levels: _____	6 month pain levels: