# MLS Laser Therapy  Patient Registration

Name: _____

Address: _____

City/ State/ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ E-mail Address: _____

Chief Complaint: _____

_____

Length of time with this condition: _____

How did you hear about MLS Laser Therapy? _____

Pain Level (circle one)


Please check any of the following that apply to you:

___ Take medication that increases sensitivity to sunlight
___ Have a seizure disorder that is triggered by light
___ Have hemorrhagic diatheses
___ Been injected with steroids in the past 2-3 weeks
___ Have history of cancerous lesion(s)
___ Take anticoagulants
___ Pregnant
___ HIV positive
___ Have a pacemaker
___ Leukemia

Please list all current medications: _____

_____

_____