ONE GREAT PLACE TO GET WELL

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DOCTOR MEL'S Wellness Spa SERVICES

Today's Date

TELL US ABOUT YOURSELF

Patient Name: _____ (Last) _____ (First) ____ (MI) Nickname: _____ ◯Male ◯Female

Birthdate: Age: ___ SS#: _____ Primary Phone#: _____ Alt. Phone#: _____

Mailing Address: _____ (City) _____ (State) _____ (Zip) Email Address: _____

Status: ◯Minor ◯Single ◯Married ◯Divorced ◯Separated ◯Widowed ◯Significant Other

Race/Ethnicity: ◯White ◯Black/African American ◯Hispanic/Latino ◯Asian ◯American Indian/Alaska Native ◯Native Hawaiian/Pacific Islander

Emergency Contact: _____

When did your condition/accident occur:

Please explain what happened:

Is your condition getting worse? ◯Yes ◯No ◯Constant ◯Comes and goes

Has this ever happened before? ◯Yes ◯No

Have you ever been treated by a Medical Physician for this condition? ◯Yes ◯No

What have you tried in the past for this condition? ☐Nothing ☐Pain Management ☐Shots ☐Pain Pills/Muscle Relaxers ☐Adjustments ☐Traction ☐Surgery

Are you currently taking photosensitive medications? (ex: accutane, tetracycline, anti-fungal medication) ◯Yes ◯No

Have you had corticosteroids in the past week? ◯Yes ◯No

Do you have or have you had any of the following diseases, medical conditions or procedures?

(Y)(N) Heart Attack/Stroke	(Y)(N) Tuberculosis
(Y)(N) Artificial Valves	(Y)(N) Venereal Disease
(Y)(N) Shingles	(Y)(N) Rheumatic Fever
(Y)(N) Emphysema/Asthma	(Y)(N) Glaucoma
(Y)(N) Ulcers/Colitis	(Y)(N) Frequent Neck Pain
(Y)(N) Cancer	(Y)(N) Frequent Low Back Pain
(Y)(N) Chemotherapy	(Y)(N) Heart Murmur
(Y)(N) Hepatitis	(Y)(N) Arthritis
(Y)(N) High/Low Blood Pressure	(Y)(N) Sinus Problems
(Y)(N) Alcohol/Drug Abuse	(Y)(N) Congenital Heart Defect
(Y)(N) Psychiatric Problems	(Y)(N) High Cholesterol
(Y)(N) Fainting/Seizures/Epilepsy	

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment that any fees for professional services rendered tome will be immediately due and payable. I understand and agree that if charges are to be filed with an insurance carrier that health and accident insurance carrier and myself. Furthermore, I understand that DR. MEL YOUNGS, D.C., P.A. will prepare any necessary forms to assist me in making collection from my insurance carrier and that any amount authorized will be paid directly to DR. MEL YOUNGS, D.C., P.A. and will be credited to my account upon receipt. I understand that DR. MEL YOUNGS, D.C., P.A. is acting solely as an agent for me in filing to my insurance carrier for benefits assigned to me and authorize release of any information re-quired to support my claim. However, DR. MEL YOUNGS, D.C., P.A. can assume no responsibility for guaranteeing payment of covered services. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier as well as any attorney fees and costs incurred to collect for these services.

_____ Initials

I clearly understand that I am personally responsible for payment of any professional services rendered to me. I have been explained the potential benefits and side-effects of Class IV Laser Therapy. I understand the Doctor's recommendations for a series of treatments, but I also understand that there is no guarantee of results. I understand that these treatments are non-transferrable.

Laser therapy is a safe and effective therapy that is FDA cleared for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Laser also promotes relaxation of muscle spasm and promotes vasodilation. Adverse effects from laser therapy are normally rare and temporary.

Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks. However, your results may be minimal or insignificant. Adverse effects of laser therapy may occur from multiple causes including hypersensitivity, preexisting health conditions, thermal effects, excessive pressure from the probe, and laser over-stimulation. Laser light can damage the retina in your eye. Always wear the laser protective glasses provided.

The most common adverse effects are:
1. Temporary increase in pain during application of laser.
2. Temporary increase in pain the following day after laser therapy.
3. Mild bruising from vasodilation or direct pressure of laser tip.
4. Temporary dizziness.
5. Reactions when photosensitizing drugs are used with laser therapy.

I understand the risks of laser therapy and agree to the treatment program outlined by my doctor.

Patient Signature: _____ Date: _____

Please Print Name: _____

Employee Witness: _____ Date: _____