filosofi
Laser and Massage

PATIENT INFORMATION SHEET – Laser and Physiotherapy

Name: _____ **Date:** _____ **Sex: M / F**

Address: _____ **City:** _____ **Postal Code:** _____

Home Phone #: _____ **Work Phone #:** _____

Employer: _____ **Dr's Name / Ph. #:** _____

Date of Birth: _____ **Email Address:** _____

Would you like to be signed up for Filosofi's quarterly newsletter that contains information, upcoming specials and important dates? Yes No
(Please note that your email address will never be giving to a 3rd party for any reason and will only be used by Filosofi for the purpose of our internal emails)

How did you hear about us? _____

Current Health Habits	Yes	No	Patients Comments	Doctor's Comments
Did/do you smoke?				
Did/do you drink any alcohol?				
Are you concerned about your diet?				
Have you been in accidents?				
Current medications? How Long?				
Allergies?				
Exercise regularly?				
Females; Are you pregnant?				
Sleeping posture ☐ side ☐stomach ☐back				

Is there a family history of: Heart Disease ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Other _____

Present Complaint: _____

Pain or problem started on _____
Pains are: Sharp ☐ Dull ☐ Constant ☐ Intermittent ☐
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is condition worse during certain times of the day? _____
Is this condition interfering with your work? ____ Sleep? ____ Daily Routine? ____ Other? ____
Is condition getting progressively worse? _____
Have you seen any other Doctors seen for this condition? _____
Any effective treatments? _____
Have you experienced any side effects from the drugs and surgeries? _____

Other Symptoms:

☐	Headaches	☐	Pins and Needles in legs	☐	Fainting
☐	Neck Pain	☐	Pins and Needles in Arms	☐	Loss of Smell
☐	Sleeping Problems	☐	Numbness in Fingers	☐	Loss of Taste
☐	Back Pain	☐	Numbness in Toes	☐	Diarrhea
☐	Nervousness	☐	Shortness of Breath	☐	Feet Cold
☐	Tension	☐	Fatigue	☐	Hands Cold
☐	Irritability	☐	Depression	☐	Stomach Upset
☐	Chest Pains	☐	Lights Bothers Eyes	☐	Constipation
☐	Dizziness	☐	Loss of Memory	☐	Cold Sweats
☐	Face Flushed	☐	Ears Ring	☐	Loss of Balance
☐	Neck Stiff	☐	Fever	☐	Buzzing in Ears

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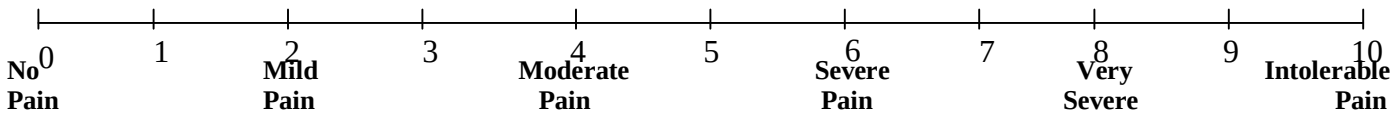
Patient Pain Assessment

0-10 Numeric Pain Intensity Scale (1)



1) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain Intolerable Pain

2) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain Intolerable Pain

3) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0 1 2 3 4 5 6 7 8 9 10
No Pain Intolerable Pain

4) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10
No Pain Intolerable Pain

5) What treatments or medications are you receiving for your pain? _____

6) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

B. Walking ability

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

C. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

D. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

E. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes