



Dr. Linda Oswell, B.Sc. (Hon), D.C.
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Confidential Patient History - Laser

Name: _____ Date: _____
 Address: _____ City: _____ Province: _____
 Postal Code: _____ Home Phone #: _____ Work Phone # / Other #: _____
 Employer: _____ Dr.'s Name _____
 Date of Birth: _____ Sex: M / F MVA? _____ WSIB? _____
 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?				
Sleeping posture: side stomach back				
Females: Are you pregnant?				
Stress: physical, emotional, chemical?				
Did/do you have cancer? Type?				

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 ___ Travels ___ Comes & goes _____

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? ___ Walking? ___ Sitting? ___

Hobbies? ___ Other? _____

Is condition getting progressively worse? _____

Have you seen any other Doctors for this condition? _____

Any effective treatments? _____

Have you experienced any side effects from the drugs and surgeries? _____

Other Symptoms:

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

PATIENT PAIN ASSESSMENT
0-10 Numeric Pain Intensity Scale

Example: No pain, Mild pain, moderate pain, severe pain, very severe, intolerable pain

- 1) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.
No pain 1 2 3 4 5 6 7 8 9 10 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.
No pain 1 2 3 4 5 6 7 8 9 10 intolerable pain
- 3) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.
No pain 1 2 3 4 5 6 7 8 9 10 intolerable pain
- 4) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.
No pain 1 2 3 4 5 6 7 8 9 10 intolerable pain
- 5) What treatments or medications are you or have you received for your pain? _____
- 6) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:
 - A. General activity: Does not interfere 1 2 3 4 5 6 7 8 9 10 completely interferes
 - B. Walking ability: Does not interfere 1 2 3 4 5 6 7 8 9 10 completely interferes
 - C. Normal work: [includes both work outside and inside the home]
Does not interfere 1 2 3 4 5 6 7 8 9 10 completely interferes
 - D. Sleep: Does not interfere 1 2 3 4 5 6 7 8 9 10 completely interferes
 - E. Enjoyment of life: Does not interfere 1 2 3 4 5 6 7 8 9 10 completely interferes

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PATIENT CONSULTATION –Laser

Name: _____ Date: _____

Main Complaint: _____

History of Problem: _____

Duration of Symptoms: _____

Prior Therapy for current Conditions: _____

Physical Examination: _____

Diagnosis: _____

Report of Findings _____

Tests Required: _____

Treatment Plan: _____

