Madison Laser Therapy

720 Hill Street #200
Madison, WI 53705
(608) 628-4015

Client Intake

Name:		Date: / /	
Address (Line 1):			
Address (Line 2):			
City:	State:	Zip:	
Primary Phone: ( ) -	Alt. Phone: ( ) -		
Email:			

~ Please list your medications and the conditions for which they are used. ~

Medication Name	Condition(s)

Please check the following boxes	Yes	No
Are you now taking or have you recently taken any steroid medication?		
Are you now taking or have you recently taken any anticoagulants?		
Are you now taking or have you recently taken any cholesterol medication?		
If so, are you supplementing with coenzyme Q-10?		
Do you have epilepsy?		
Have you had a cortisone shot within the last 72 hours?		
Do you have any chronic pain?		
If so, where on your person?		
What do you hope to gain from your Laser Therapy treatments?		
How did you learn about Madison Laser Therapy?		
Friend or Family _____	Internet Search _____	Newspaper _____	Radio _____

I understand that if I need to reschedule an appointment for any reason, I will give at least 24 hours notice or be responsible for half the session fee. If I don't call or show up for the appointment, I will be responsible for the full session fee. I certify that the above information is true and accurate to the best of my knowledge.

Client Signature: _____

Signature of parent/guardian if client is under 18: _____

Date: _____/_____/_____