1539 Florida Rd.
Suite 112
Durango, CO. 81301

Animas Laser Therapy

www.altdurango.com
(970) 422-8510
Find us on

Thank you for taking the time to fill out this overview form. This information will greatly assist us in helping you achieve your health and wellness goals. ***All information is strictly confidential.***

About You

Name: _____Preferred Pronoun(s):_____

Address: _____

City: _____ State: _____ Zip:_____

Date of Birth: (MM/DD/YYYY): _____ Sex at Birth (M or F): _____

Occupation: _____ Age:_____

.....

Telephone: _____ Email: _____

Emergency Contact Name: _____ Phone: _____ Relation: _____

How did you hear about Animas Laser Therapy? _____

Would you like to be on our email list? Y N *(Your information will never be given to any other person or business.)*

Other healthcare providers:

1. Name: _____
   Profession: _____
   Phone: _____

2. Name: _____
   Profession: _____
   Phone: _____

3. Name: _____
   Profession: _____
   Phone: _____

4. Name: _____
   Profession: _____
   Phone: _____

What Brings You In?

Present Issue: _____

Date Problem Began: _____

How did your problem begin? Specific event Multiple events Gradually developed No apparent reason

Briefly describe the onset in more detais: _____
_____

Your problem is: Constant intermittent

Your problem is worse during: Morning Afternoon Evening No Difference

How would you describe the pain in your own words? (examples: sharp, dull, achy, electrical, etc.) _____

On a scale of 0-10 (10 being the worst pain imaginable) how bad is your pain right now?_____ At the worst?: _____

Does anything increase or decrease your pain? _____

Have you had a similar problem before? Yes No

Have you received prior care for this issue? Yes No If yes, what? _____
_____

Current Symptoms

☐ Fever	☐ Fatigue	☐ Weight Loss	☐ Diarrhea
☐ Poor Circulation	☐ Night Sweats	☐ Sore Throat	☐ Rash
☐ Tingling	☐ Numbness	☐ Weakness	☐ Locking, popping, or catching of joints
☐ Dizziness	☐ Chest Pain	☐ Difficulty Breathing	☐ Cough
☐ Muscle Weakness	☐ Painful/swollen Joints	☐ Tension	☐ Bruising
☐ Loss of Bowel or Bladder Control	☐ Nausea	☐ Vomiting	☐ Constipation
☐ Difficulty Sleeping	☐ Anxiety	☐ Hot Flashes	☐ Changes in vision
☐ Urinary Tract Infection	☐ Immune Dysfunction	☐ Respiratory Infection	☐ Difficulty Swallowing
☐ Pain with coughing, sneezing, or bearing down	☐ Instability or giving way	☐ Bleeding	☐ Other:

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Patient Name:_____ DOB:_____ Provider:_____ Date:_____

Personal Medical History

☐ Diabetes	☐ Ulcers	☐ Cancer	☐ AIDS/HIV
☐ Joint Replacement	☐ Stroke	☐ Arthritis	☐ Seizures
☐ Glaucoma	☐ Hepatitis	☐ Anemia	☐ Alcoholism
☐ Lung Disease	☐ Heart Disease	☐ Diverticulitis	☐ Pacemaker
☐ Kidney Disease	☐ Thyroid Disease	☐ Tuberculosis	☐ Hypertension
☐ Blood Thinners	☐ Depression	☐ Anxiety	☐ Allergies:_____

Any other conditions not listed above?: _____

Date and findings of last **physical exam**:

_____

_____

Please list any past **surgeries or hospitalizations**: Date:

_____ _____

_____ _____

_____ _____

Please list all **past injuries** (ie. broken bones, joint sprains, burns, falls, car accidents, etc.): Date:

_____ _____

_____ _____

_____ _____

Supplements & Drug Medications

Please list all **current** medications, vitamins, minerals, herbs, or homeopathic remedies.

Medication/Supplement	Dose/day	How long	Reason for Supplement
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are these well tolerated? Y N If no, please list the adverse reactions or side effects and from what medication:

_____

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Patient Name:_____ DOB:_____ Provider:_____ Date:_____

Activities of Daily Living

Please check all that apply and specify frequency/amount.

- ☐ Caffeine:_____
- ☐ Soda:_____
- ☐ Alcohol:_____
- ☐ Recreational Drugs:_____
- ☐ Tobacco:_____
- ☐ Red Meat:_____
- ☐ Hours of sleep per night:_____
- ☐ Difficulty sleeping:_____
- ☐ Physical Activity:_____
- ☐ Chemical Exposure:_____
- ☐ Number of meals per day:_____
- ☐ Water consumption per day:_____
- ☐ Social Support:_____

Please list all allergies (food, medication, environmental):

_____

_____

_____

Any additional information about your health that you would like to share: _____

_____

_____

Family History

*Please indicate whether any **family members** have had any of the following: (Include parents, siblings, maternal grandparents (MGP), paternal grandparents (PGP), aunts, uncles. Include age and cause of death if applicable.)*

	Relation to you		Relation to you
☐ Alcoholism	_____	☐ Diabetes	_____
☐ Alzheimer's Disease	_____	☐ Heart Disease	_____
☐ Arthritis	_____	☐ High Blood Pressure	_____
☐ Asthma	_____	☐ Kidney disease	_____
☐ Autoimmune condition	_____	☐ Osteoporosis	_____
☐ Cancer (indicate type)	_____	☐ Thyroid Condition	_____
☐ Stroke	_____	☐ Other Medical Illness	_____

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Patient Name:_____ DOB:_____ Provider:_____ Date:_____

ANIMAS LASER THERAPY, LLC
INFORMED CONSENT AND AGREEMENT TO RECEIVE
LOW-LEVEL LASER THERAPY (LLLT) & WELLNESS CONSULTATION

I, _____ agree to and understand the following:

1. **NOT A REPLACEMENT FOR MEDICAL CARE; PRESCRIPTION CHANGES**: Services provided at Animas Laser Therapy, LLC are not a substitute for primary or specialized medical care and do not take the place of medical evaluation. Please consult with all of your health providers about services recommended by and received in this office. DO NOT alter any medical treatment plan or prescriptions without the approval of your physician. By signing this consent, you agree to discuss any and all services with your physician and to tell your physician about the services you receive.

2. **NO GUARANTEE:** Individual results vary and Animas Laser Therapy, LLC does not guarantee or otherwise promise any results. The services provided are intended only to support fat reduction and body contouring, and support pain management through reduction of inflammation and increased blood flow, the success of which is NOT guaranteed.

3. **CONTRAINDICATIONS, INCLUDING PREGNANCY**: Women who are pregnant or may be pregnant should not receive Low-Level Laser Therapy. By signing this form, I represent that I am not pregnant and that I have consulted with my primary care physician or another specialist physician regarding whether I may be pregnant. I further understand that I should not receive Low-Level Laser Therapy if I have any of the following and I represent that I DO NOT have:

   - cancerous, or potentially cancerous lesions
   - carcinoma
   - epilepsy
   - any photosensitizing skin condition or take any photosensitizing medication
   - hyperthyreosis

4. **RISKS**: The services provided by Animas Laser Therapy, LLC have some risks. While no serious adverse outcomes have ever been reported with Low-Level Laser Therapy, I understand that unforeseeable risks may be present in any modality and I accept these risks at my own willful volition. Such risks may include, but are not limited to, burns, discoloration, mild discomfort, and/or pain. I understand that my symptoms may temporarily worsen upon first starting laser therapy, especially symptoms from old injuries and chronic pain. Nutritional recommendations, including dietary supplements, vitamins, minerals, herbs, and other nutrients are generally considered safe; however, they involve some risks including, without limit, changes in blood sugar, gastrointestinal upset, allergic reaction, and toxicity. They may also interact with some drugs and may be inappropriate during pregnancy. Accordingly, you should consult with your prescribing provider about any drugs you are taking, and immediately report pregnancy and any adverse effects to all care providers.

5. **ALTERNATIVES:** Alternatives include declining our services and consulting with other providers.

6. **LIMITED LIABILITY**: You agree on behalf of yourself (and your personal representatives, heirs, executors, administrators, agents and assigns), to the maximum extent permitted by law, to waive, release, and discharge Animas Laser Therapy, LLC and it's employees, agents, and representatives from any and all liability, claims, or causes of action arising out of alleged acts or failures to act, including liability, claims, or causes of actions resulting from negligence. This consent and agreement is intended to be a complete release of liability to the greatest extent allowed by law and if any portion is held to be invalid, the remainder shall be valid. This waiver and release of liability includes, without limit, injuries that may occur as a result of your use of equipment, services, or facilities, and any instruction and/or supervision received while at Animas Laser Therapy, LLC; and slipping and/or falling while in or on the premises and/or therapeutic care in any healing modalities.

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Patient Name:_____ DOB:_____ Provider:_____ Date:_____

7. **REVIEW AND AGREEMENT**: By signing this Informed Consent and Agreement, you acknowledge that you have received a copy of this document and that you have read, and fully understand and agree to its terms.

8. **PROVISION OF SERVICES BY NON-PHYSICIAN**: By signing this Informed Consent and Agreement, you acknowledge that you have read the following information related to the provision of services at Animas Laser Therapy, LLC and that you consent to such services:

   a. Services may be delegated to the staff, some of whom may NOT be licensed health care providers, at the discretion of the designated Medical Director.

   b. Services that are medical services are provided pursuant to delegated authority by the Animas Laser Therapy, LLC Medical Director;

   c. Dr. Nathan Mitton, DC is the Medical Director for Animas Laser Therapy;

   d. The Medical Director is available personally to consult with you and provide evaluation or treatment in relation to the delegated services;

   e. Upon your request, the Medical Director will timely and personally provide consultation, evaluation or treatment, and will provide appropriate follow-up care and/or referrals.

9. **PAYMENT, INSURANCE, AND REFUNDS:** Payment for services is not conditional on response. This office does not accept insurance. Any insurance you have is an agreement between you and your insurance carrier and you are responsible for payment of services, whether or not they are covered by insurance. Prorated fees for unused, prepaid services will be refunded if you wish to cancel; however, no refunds are available for products purchased or services rendered.

STOP!
DO NOT SIGN BELOW IF YOU HAVE NOT READ
OR DO NOT UNDERSTAND THE ENTIRE INFORMED CONSENT AND AGREEMENT

By signing this Informed Consent and Agreement, you acknowledge that you have carefully read and understand this document and understand that you should not sign this form if any of your questions have not been answered or if you do not understand any of the terms. By signing this Informed Consent and Agreement you release Animas Laser Therapy, LLC, its owners, employees, providers, affiliates, and representatives from all liability. You agree to waive any right to bring legal action to or assert any claim against Animas Laser Therapy, LLC. I have read and fully understand this Informed Consent and Agreement.

_____ _____

Patient or Person with Authority to Consent **Date**

_____ _____

Witness **Date**

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Patient Name:_____ DOB:_____ Provider:_____ Date:_____