Treatment Consent Form

Date 2/28/04

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name Theresa Collins Age 49 Gender F

Street Address 2298 W. Liddell Rd

City Duluth State GA Zip 30096

Email TheresaDCollins@hotmail.com Phone (770) 8490523

1. Where is your pain? right arm
2. What caused it? repeated movement @ pre-K school
3. Approximately when did it start? 1 year
4. Is it getting worse, better or staying the same? Staying the same
5. What activity(s) does it interfere with? picking up items, Reaching for items
6. What is your pain right now? (circle #) 0 . . . 1 . . . 2 . . . (3) . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
   Mild — Moderate — Severe/Agony

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Patient (or Parent) Signature Theresa Collins Witnessed by

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

Reduced aching in elbow area when extended.

(For Office Use Only)

Pre-treatment sign:

Pre-treatment Pain level:

RESULTS:

1/10

Treatment remarks:

Treatment Provided by:

Treatment Consent Form

Date 1-2-08

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name ROBERT A BONIKAS Age 78 Gender M

Street Address 17711 COLLIE

City HB State CA Zip 92647

Email - Phone (714) 8425010

1. Where is your pain? Leg
2. What caused it? ?
3. Approximately when did it start? 3wks
4. Is it getting worse, better or staying the same? SAME
5. What activity(s) does it interfere with? WALKING
6. What is your pain right now? (circle #) 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . (6) . . . 7 . . . 8 . . . 9 . . . 10
   Mild Moderate Severe/Agony

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Patient Signature [signature] Witnessed by Esther Bonikas

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

Everything that I complained about is gone. I feel a lot better. From a 6 to a 1. I Feel a little pain.

(For Office Use Only)

Pre-treatment sign:

Pre-treatment Pain level:

RESULTS:

1/10

Treatment remarks:

Treatment Provided by:

Treatment Consent Form

Date 1/3/2005

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name Rob Adams Age 50 Gender M

Street Address 2430 E. Hwy 153

City Beaver, State UT Zip 84713

Email rga@cimasolutions.com Phone (435) 438-1716

1. Where is your pain? Left Shoulder
2. What caused it? Unsure - 6 month chronic pain
3. Approximately when did it start? May / June 2004
4. Is it getting worse, better or staying the same? Staying the Same
5. What activity(s) does it interfere with? ______
6. What is your pain right now? (circle #) 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . (6) . . . 7 . . . 8 . . . 9 . . . 10
   Mild — Moderate — Severe/Agony
   When I extend

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Patient (or Parent) Signature [signature] Witnessed by ______

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

I felt nothing during treatment. After treatment, my shoulder feels somewhat different pain is definitely less than before. I am waiting to see what I will feel like in the morning.

A positive experience overall!

(For Office Use Only)

Pre-treatment sign:

Pre-treatment Pain level:

RESULTS:

Treatment remarks:

Treatment Provided by:

Treatment Consent Form

Date 1/3/2005

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name Esther Bonillas Age 80 Gender F

Street Address 17711 Collie Ln

City Huntington Bch Ca State Ca Zip 92647

Email ______ Phone (714) 842-5010

1. Where is your pain? Back
2. What caused it? ?
3. Approximately when did it start? 1 year a go
4. Is it getting worse, better or staying the same? Same
5. What activity(s) does it interfere with? Walking
6. What is your pain right now? (circle #) 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . (5) . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
   Mild — Moderate — Severe/Agony

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Patient Signature Esther Bonillas Witnessed by [signature]

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

2/10 – Feels almost no pain. Better then when she got it the first time.

(For Office Use Only)

Pre-treatment sign:

Pre-treatment Pain level: 5/10

RESULTS: 2/10

Treatment remarks:

Treatment Provided by: maggie

Treatment Consent Form

Date 1-3-05

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name Geri Gonzalez Age 57 Gender F

Street Address 18962 Hathy Way

City Corona State CA Zip 92881

Email ____ Phone (951) 273-7902

1. Where is your pain? Bone Spur (heels)
2. What caused it? ____
3. Approximately when did it start? 2-3 years ago
4. Is it getting worse, better or staying the same? better since treatment
5. What activity(s) does it interfere with? walking
6. What is your pain right now? (circle #) 0 . . . 1 . . . 2 . . . 3 . . . (4) . . . 5 . . . (6) . . . 7 . . . 8 . . . 9 . . . 10 (L: 4, R: 6)
   Mild Moderate Severe/Agony

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Patient Signature Geri Gonzalez Witnessed by Carlos [illegible]

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

Felt less pain in both feet. Could feel throbbing in one or two places on each foot as I was treated. Considerable less pain after treatment. Able to walk with very little pain

(For Office Use Only)

Pre-treatment sign:
pain c̄ sustained sitting > 35 min. pain increases to 8/10 c̄ stretching of achilles tendon (B) ✗2

Pre-treatment Pain level:
(L) heel = 4/10
(R) heel = 6/10

RESULTS:
(L) heel = 1/10
(R) heel = 2/10

Treatment remarks:
4 J to (B) Achilles Tendon attachment to calcaneus centrally, medially, laterally & also 4 J to inferior surface calcaneus (B)
~ 20 minutes total 10 min / heel.

Treatment Provided by:
Carlos Y. Romero MPT

Treatment Consent Form

Date 1/3/05

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name Jose Aviña Age 42 Gender Male

Street Address 3581 Raven st.

City Lake Elsinore State Ca Zip 92530

Email ______ Phone (951) 674-3473

1. Where is your pain? L back
2. What caused it? He lifted heavy things
3. Approximately when did it start? 10/22/03
4. Is it getting worse, better or staying the same? worsening
5. What activity(s) does it interfere with? sleep, sitting
6. What is your pain right now? (circle #) 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . (8) . . . 9 . . . 10
   Mild — Moderate — Severe/Agony

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Patient Signature [signature] Witnessed by ______

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

It helped me a lot
I feel a lot better.
The pain went from
an 8 to a 4.

4/10

(For Office Use Only)

Pre-treatment sign:

Pre-treatment Pain level:

RESULTS:

4/10

Treatment remarks:

Treatment Provided by:

Treatment Consent Form

Date 1/3/04

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name MARY CANZONE Age 67 Gender F

Street Address 37205 Wild Rose LN.

City Murrieta State CA Zip 92562

Email mickbill@earthlink.net Phone (951) 696-1763

1. Where is your pain? lower back - rt side
2. What caused it? ?
3. Approximately when did it start? 1yr ago
4. Is it getting worse, better or staying the same? same
5. What activity(s) does it interfere with? most things
6. What is your pain right now? (circle #) 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . (6) . . . 7 . . . 8 . . . 9 . . . 10
   Mild — Moderate — Severe/Agony

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Patient Signature Mary Canzone Witnessed by

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

7-8/10 pain (R) SI region/gluteal
GP, PT

I do feel relief after the treatment. I will try other treatments along with my PT.

(For Office Use Only)

Pre-treatment sign:
pain c palpation

Pre-treatment Pain level:
7-8/10

RESULTS:
4-5/10 post tx
↓'d tenderness to palpation

Treatment remarks:

Treatment Provided by: Gina Paino, PT

Treatment Consent Form

Date 1/3/05

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name Justyn Snell Age 15 Gender F

Street Address 40454 Calle Katerine

City Temecula State CA Zip 92591

Email Phone ( ) 699-3127

1. Where is your pain? Right Knee
2. What caused it? Soccer injury - ACL surgery
3. Approximately when did it start? April 1st
4. Is it getting worse, better or staying the same? getting worse
5. What activity(s) does it interfere with? competitive sports.
6. What is your pain right now? (circle #) 0 . . . 1 . . (2) . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10 — Mild / Moderate / Severe/Agony

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Patient (or Parent) Signature Julie C. Snell. Witnessed by

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

My knee feels more relaxed, and I am able to bend it more, with less pain

(For Office Use Only)

Pre-treatment sign:

Pre-treatment Pain level:

RESULTS:

Treatment remarks:

Treatment Provided by:

Treatment Consent Form

Date 12/28/04

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name TOMAS W. BRAGANZA Age 84 Gender M

Street Address 9191 Florence

City Downey State Cal Zip

Email Phone ( )

1. Where is your pain? BACK - SHOULDERS - FEET
2. What caused it? PUTING UP CHRISTMAS DECOR
3. Approximately when did it start? 4 days before Christmas
4. Is it getting worse, better or staying the same? Same
5. What activity(s) does it interfere with? Walking - FEET
6. What is your pain right now? (circle #) 0 . . . 1 . . . 2 . . . 3 . . . 4 . . (5) . . 6 . . . 7 . . . (8) . . 9 . . . 10
   Mild — Moderate — Severe/Agony

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Patient (or Parent) Signature Tomas W. Braganza Witnessed by

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

Felt big difference right away.
My pain had decrease significantly.

(For Office Use Only)

Pre-treatment sign:

7/10

Pre-treatment Pain level:

RESULTS:

2/10

Treatment remarks:

Treatment Provided by:

Treatment Consent Form

Date 12-28-04

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name GENEROSO C. SISON Age 67 Gender M

Street Address 10726 CLARIDGE PL.

City WHITTIER State CA Zip 90603

Email ______ Phone (562) 943-7939

1. Where is your pain? RT. SHOULDER + AROUND WAIST
2. What caused it? ______
3. Approximately when did it start? 1 YR. AGO + 10 YRS AGO
4. Is it getting worse, better or staying the same? SAME
5. What activity(s) does it interfere with? RAISING RT. HAND + BENDING DOWN
6. What is your pain right now? (circle #) 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . (5) . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
   Mild / Moderate / Severe/Agony

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Patient (or Parent) Signature Generoso C. Sison Witnessed by ______

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

After the treatment the pain on my RT. shoulder diminished.

(For Office Use Only)

Pre-treatment sign:

Pre-treatment Pain level:

RESULTS:

↑ motion

↓ pain 1/10

Treatment remarks:

Treatment Provided by:

Treatment Consent Form

Date 1-4-05

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name [illegible] Age 59 Gender F Email

Street Address 5286 Orange Ave City Long Beach

State CA Zip 90805 Phone (562) 422-0291 Occupation

1. Where is your **MOST** painful area? neck to shoulder, back
2. What caused it?
3. Approximately when did it start? long time
4. What activity(s) does it interfere with?
5. What is your pain right now? (circle #) 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . (8) . . 9 . . . 10
   Mild Moderate Severe/Agony
6. What other types of treatment have you already received for this problem? pain killer Tablets

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Patient (or Parent) Signature [illegible] Witnessed by

(Patient Completes after Treatment)

Please describe your experience with the 830Laser treatment.

Pain went down to 3

How did you hear about us?

Treatment remarks:

Treatment Provided by:

Treatment Consent Form

Date 01/03/05

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name Buddie Carson Age 74 Gender M

Street Address 30091 Iron Horse Dr.

City Murrieta State Ca Zip 92563

Email ____ Phone (951) 894-4649

1. Where is your pain? Lower back
2. What caused it? Chronic
3. Approximately when did it start?
4. Is it getting worse, better or staying the same? better
5. What activity(s) does it interfere with? everything
6. What is your pain right now? (circle #) 0 . . . 1 . . . (2) . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
   Mild — Moderate — Severe/Agony

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Patient Signature Buddie L. Carson Witnessed by ____

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

The treatment was very soothing & comfortable. I could feel the warmth from the laser. It helped the middle of my back & eased the pain -

(For Office Use Only)

Pre-treatment sign:

Pre-treatment Pain level: 2/10

RESULTS: relief of central pain 1 spot remains 1-2/10

Treatment remarks:

Treatment Provided by: Maggie

Treatment Consent Form

Date 01/03/05

In order to understand your condition and provide the best treatment, please be honest and accurate.

Patient Name JOHN JOHNSON Age 45 Gender M

Street Address 39926 CANON CT.

City TEMECULA State CA Zip 92591

Email jjohnson14@adelphia.net Phone (760) 802-0417

1. Where is your pain? (L) index finger
2. What caused it? broke
3. Approximately when did it start? 10 weeks ago
4. Is it getting worse, better or staying the same? better slowly
5. What activity(s) does it interfere with?
6. What is your pain right now? (circle #) 0 . . . 1 . . . 2 . . . (3) . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
   Mild — Moderate — Severe/Agony

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Patient Signature J. Johnson Witnessed by

(Patient Completes after Treatment)

Please describe your experience with laser treatment.

Pain level is lower when exercising joint Flexibility increased noticeably —

(For Office Use Only)

Pre-treatment sign:

Pre-treatment Pain level:

RESULTS:

1/10

Treatment remarks:

Treatment Provided by: