

Journey Through Healing Chiropractic Center, LLC

830 Saginaw Street South
Salem, OR 97302

Tel 503-480-0200 Fax 503-480-0203
journeythroughhealingchiropractic.com



Laser Therapy Information and Consent

Laser Therapy is a safe and effective therapy that is FDA cleared for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Laser also promotes relaxation of muscle spasm and promotes vasodilation. Pain relief from Laser therapy may be dramatic and substantial, lasting hours, days, or weeks. However, your results may be minimal or insignificant. Adverse effects of Laser therapy may occur from multiple causes including hypersensitivity, pre-existing health conditions, thermal effects, laser overstimulation. Laser light can damage the retina in your eye. Always wear the protective glasses provided.

The most common adverse effects are:

Temporary increase in pain the following day after Laser therapy, Mild bruising from vasodilation, Temporary dizziness, Reaction when photosensitizing drugs are used with Laser therapy, Temporary sleepiness.

Please check if any of the following medications, treatments, or conditions applies to you:

- | | |
|--|--|
| <input type="checkbox"/> Using Photosensitizing drugs such as steroids | <input type="checkbox"/> Taking any cycline drugs such as tetracycline |
| <input type="checkbox"/> Recent cortisone injections (within a week) | <input type="checkbox"/> Taking Immunosuppressant drugs |
| <input type="checkbox"/> On Dialysis | <input type="checkbox"/> Meningitis or Encephalitis |
| <input type="checkbox"/> Pregnant Female | <input type="checkbox"/> Pacemaker and or other electronic implants |
| <input type="checkbox"/> Areas of large bruising and or hemorrhage | <input type="checkbox"/> Tattoos |
| <input type="checkbox"/> Areas with decreased sensory perception | |

Attention:

You will need to double your water intake after having Laser therapy, this is going to flush out the toxins, hydrates your tissues, and lubricates your joints.

- *My signature acknowledges that I have read and understand the risks of Laser therapy and agree to the treatment program outlined by my doctor.*

Patient Name (print): _____

Patient Signature: _____ Date: _____

For office use only:

Employee witness signature: _____