



Laser Therapy Admit Form

CLIENT NAME:

PET NAME:

BEST CONTACT #:

WEIGHT:

What pain level do you believe your pet is today? Pain score is 0-4 (0 is no pain; 4 being worst).

0 1 2 3 4

What area(s) of the body do you believe are most painful?

What activities or tasks does your pet has difficulties with?

Have you seen any improvements with previous treatments?

YES

NO

N/A (1st time)

Does your pet have any metal implants from previous surgeries?

YES

NO

Does your pet have any known cancerous tumors?

YES

NO

Please list your pet's typical diet:

Has your pet eaten today?:

Is your pet on any medications? Which ones and how often are they given?

Any other questions or concerns that you'd like the doctor to review?

A staff member will contact you when your pet is ready to be picked up.

(FOR HOSPITAL USE ONLY)

LASER TECH: _____ LAST TREATMENT DATE: _____ ENTERED INTO AVIMARK _____

Areas to treat: SKIN LESION: _____ OTHER: _____

SHOULDERS ELBOWS CARPI HIPS STIFLES TARSI CERVICAL THORACIC LUMBAR

DVM REVIEWED: _____

DVM RECOMMENDATIONS: