File # _____

INTEGRATED Health Centre

Dr. N. Bair-Patel
Dr. L. Heubner

Laser Consult

First Name: _____ Dr. Mr. Mrs. Ms. Miss Master (Circle)

Surname: _____

Street/RR#/Civic Address: _____

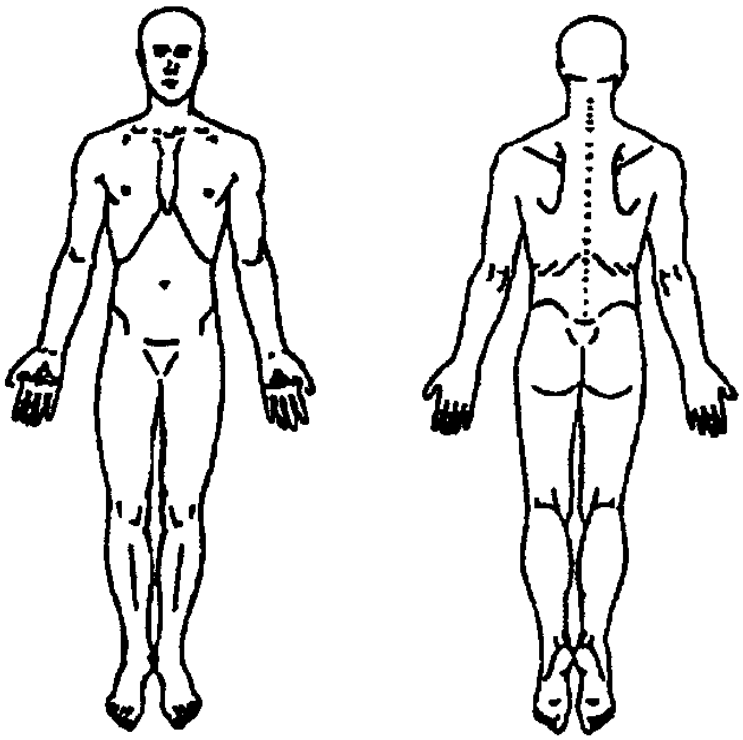
City: _____ Province: _____ Postal Code: _____

Referred by: _____

Birthdate: _____/_____/_____ Age: _____ Sex: M or F (circle)

Home Phone: (____)_____ Work Phone:(___)_____

Email: _____ Occupation: _____



Major Area of Concern

Type of Pain:

☐ Deep ☐ Superficial
☐ Dull ☐ Sharp
☐ Radiating ☐ Localized

Severity (1 mild – 10 severe): __

Made worse by: _____

_____

Relieved by: _____

_____

How long have you had this?

Now: _____

Before: _____

570 Nelson St., Pembroke ON (613) 732-3333
www.integratedhealthcentre.ca

Pain Scale:

Please rate your pain by circling the number that best describes your pain at its WORST in the past 24 hours:

0	1	2	3	4	5	6	7	8	9	10
No Pain			Mild		Moderate		Severe			Intolerable

Notes:

Date		Signature