WEDDINGTON CHIROPRACTIC
WELLNESS CENTER

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- COLD LASER THERAPY - CONSENT TO TREAT –

Cold Laser, photobiomodulation, or Low-Level Laser Therapy (LLLT) has been used successfully to treat many conditions. It is an effective therapy for musculoskeletal and neurological pain and injuries including mild to severe sprain/strains, nerve root pain, peripheral nerve pain, carpal tunnel syndrome, plantar fasciitis, and reduction of scar tissue. It has clinically been shown, when applied correctly, to result in a significantly reduced healing time and the injured tissues heal with increased function and tensile strength.

LLLT is currently being used by chiropractors, medical doctors, physical therapists, plastic surgeons, oncologists, veterinarians, etc. It is an extremely safe treatment modality, and its clinical potential is just now being developed and recognized. It has become very popular internationally for treating open wounds, pressure sores (bed sores), skin conditions, cosmetic disorders, nerve injuries, polyneuropathies (i.e., leg, hand, foot pain), and even helping patients to avoid the need for minor surgeries. It has more recently been used in the treatment of stroke patients, autism, nerve regeneration, and the reduction of keloids. **If a practitioner recommends this modality for you, before your treatment, it is important to let them know if you (please check any that apply):**

- ☐ Are pregnant
- ☐ Are being (or have been) treated for cancer
- ☐ Have any tattoos, birthmarks, or skin defects on or near the location(s) of your ailments
- ☐ Have or have had a pacemaker or other implanted electrical devices
- ☐ Are currently taking light-sensitizing medications (i.e., antibiotics, antidepressants, Retin-A, tetracycline, etc.)
- ☐ Are currently taking immunosuppressant drugs (drugs used after organ transplants)
- ☐ Are using steroids
- ☐ Are light-sensitive (sunburn easily or develop sun rashes)
- ☐ Suffer (or have suffered) from seizure disorders

Please sign below to confirm your understanding and if you can assure the above information is true and accurate to the best of your knowledge. Please inform the doctor/staff promptly if there are any changes.

_____ _____

Patient signature (or guardian) Date