Name _____DOB_____Date_____

Rock Chiropractic Extracorporeal Soft Wave Consultation History Form

Address _____City_____State_____Zip_____

Phone_____ Email_____

Are you currently a member of Law Enforcement? _____ Active or Former Military? _____

How did you hear about our office? _____

What is your #1 Health Concern you want us to help you with today?_____

How does it affect you at Home or Work? _____

Please provide the following details for your major complaint and additional health concerns:

Complaint	**How Long Suffering**	**Frequency of Pain**	**Type of Pain** (Sharp – Dull – Aching - Burning)	**Severity 1 to 10 10=Worst pain ever felt**
1.				
2.				
3.				
4.				

Please circle the following signs of stress that you experience:

- Headaches – Fatigue – Sleeplessness - Sinus/Allergy – Irritability – Neck/Mid/Low Back Pain

Was there an earlier accident or injury that is directly related to this problem?

- Fall - Auto Injury - Sports Injury- Repetitive Motion on the Job

Since you began suffering from your primary complaint, has anything helped? YES / NO

- Ice – Heat – Rest - Over-the-Counter Meds - MD Prescriptions - P.T. – Chiro - Other

Has anything you have tried thus far fixed your problem? YES / NO

If this problem did not exist, either partially or totally, what would you really like to be doing? (Hobbies, Daily Activities, etc.) _____

On a scale of 1-10, ten being the highest, rate your commitment to getting rid of the problem.

_____

Is there anything preventing you from getting this problem taken care of with treatment?

_____

Rock Chiropractic

Soft Wave Therapy Patient Consent Form

Suitability for ESWT (Extracorporeal Shockwave Therapy) also known as "The Stem Cell machine" from the TV show The Doctors.

By answering the following questions, you will assist us to decide if you are suitable for ESWT.

1. Have you been injected with cortisone this month? Yes / No
2. Are you using a cardiac pacemaker? Yes / No
3. Do you have cancer / tumor? Yes / No
4. Do you have skin infection? Yes / No
5. Are you pregnant? Yes / No

RISK OF THIS PROCEDURE

1. Pain and soreness. This is temporary and resolves after a week or less.

CONSENT FOR PROCEDURE

I, _____, The Undersigned, do hereby consent to authorize the application of

Extracorporeal Shockwave Therapy (ESWT) for my condition of: _____

_____.

I have been fully informed of focal ESWT which use has been fully explained to me by my treating physician/staff, and I fully understand the nature of this treatment. I also confirmed that I have been given the opportunity to discuss and clarify any concerns and that no guarantees have been made to me mostly for pain relief and may offer an improvement of function. I also understand foregoing treatment is not the first option for my condition and an alternate treatment has either already been provided or offered to me.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND/OR THE FORM HAS BEEN EXPLAINED TO ME. I FULLY UNDERSTAND ITS CONTENTS AND WAS GIVEN AMPLE OPPORTUNITY TO ASK ADDITIONAL QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION.

Signed _____ Date _____

Initial Below

_____ I acknowledge that NO GUARANTEES OR ASSURANCES have been made to me concerning the results of this procedure.

_____ I consent to the taking of photographs or the use of video recording equipment before, during or after the procedure for the purpose of medical education and social media marketing.

____ I voluntarily consent to allow any Physician and medical personnel under the provider's direct supervision to be involved in performing such procedures described or otherwise referred to herein.