Name: _____ DOB:_____

Address:_____

City, State, Zip:
_____

Phone: _____ Email: _____

Emergency Contact Name: _____ Relationship:_____
Emergency Contact Phone: _____

Suitability for ESWT (Extracorporeal Shockwave Therapy), also known as Softwave Tissue Regeneration Technologies

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

- Have you been injected with cortisone this month? Yes / No
- Are you using a cardiac pacemaker? Yes / No
- Do you have cancer / tumor? Yes / No
- Do you have a skin infection? Yes / No
- Are you pregnant or do you suspect you may be pregnant? Yes / No
- Are you under 16 years of age? Yes / No

What is the main concern for your visit? (Neuropathy, Shoulder Pain, Back pain..etc.)

_____

What is the pain level of your primary complaint AT ITS WORST? (0 - no pain, 10 - worst possible pain.)

0 1 2 3 4 5 6 7 8 9 10

RISK OF THIS PROCEDURE

A) Pain and soreness. This is temporary and resolves after a few days.
B) The FDA has labeled this a “Non-Significant Risk” therapy

Signature: _____ Date:_____