



SoftWave therapy

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ Legal sex: Male Female

Address: _____ City: _____ State: ____ Zip: _____

E-mail Address: _____ Phone: _____

Emergency contact Name: _____ Phone: _____

REASON FOR VISIT

Please explain the condition that brings you to our office today. _____

When did the problem(s) begin? _____ When is the problem at its worst? AM PM mid-day late PM

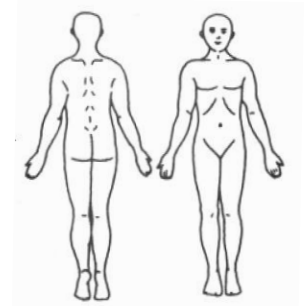
How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? No Yes **If yes**, when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching
N = Numbness **S** = Sharp/Stabbing **T** = Tingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

List any medications/supplements that you are currently taking _____

Do you have any allergies to food and/or medications? No Yes **If yes, please explain:** _____

PAIN ASSESSMENT

Instructions: Please circle the number that best describes your pain level now and your pain level on average.

1 – What is your pain RIGHT NOW? No pain _____ 0 1 2 3 4 5 6 7 8 9 10 _____ unbearable

2 – What is your TYPICAL pain? No pain _____ 0 1 2 3 4 5 6 7 8 9 10 _____ unbearable

ACTIVITIES of DAILY LIVING ASSESSMENT

Rate your current difficulties with Daily Activities, resulting from your condition, with regard to the various activities listed below.

CHECK THE APPROPRIATE BOX that most closely describes your current degree of difficulty:

- 1 = "I can do it "no difficulty",
- 2 = "I can do it without much difficulty, despite some pain"
- 3 = "I manage to do it by myself, despite marked pain"
- 4 = "I manage to do it, despite the pain, but only if I have help"
- 5 = "I cannot do it at all, because of the pain".

Activities	#1 No difficulty	#2 Some pain	#3 Difficult with pain	#4 Painful but need help	#5 Unable to perform
Standing					
Sitting					
Walking					
Bending-forward/backwards					
Twisting – right/left					
Leaning – forward/backward					
Carrying small/large objects					
Climbing stairs					
Exercising					
Sleeping					

PAST HISTORY

If you have ever been diagnosed with any of the following conditions, please place check mark in appropriate column:

C for **CURRENTLY** have P for conditions in the **PAST** N for **NEVER** have had

	C	P	N		C	P	N
Broken bones				Cancer			
Dislocations				Diabetes			
Fractures				Cardiac conditions			
Arthritis				Cerebral Vascular issues			
Rheumatoid Arthritis				Tumors			
Osteo Arthritis				Disability			
Asthma				Auto Immune disorder			
Crohn's / Colitis / IBS				Frequent ear/respiratory infections			

Please explain Current condition(s) checked above and list any conditions/ surgeries / hereditary conditions that are not listed above:

Parent Chiropractic Center requires a credit card to be kept on file in the event your account has an outstanding balance in excess of 90 days. In the event that this should happen, we will process a payment for the outstanding balance on your account with the credit card listed below.

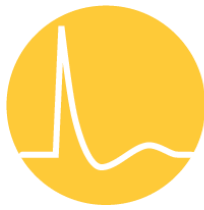
Card # _____ Exp.Date: _____ CVC code: _____
VISA / MC / Discover / AMEX

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed



SoftWave

Tissue Regeneration Technologies

Extracorporeal Shockwave Therapy (ESWT) Patient Consent Form

Date: _____

Name: _____

DOB: _____ Phone: _____

Suitability for ESWT - To determine if you are a candidate for Extracorporeal Shockwave Therapy (ESWT), please answer the following questions.

What area of the body / condition are we treating today? _____

- | | |
|---|----------|
| • 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 |
| • Do you have a history of blood clots/aneurysms? | Yes / No |
| • Do you have any autoimmune disorders? | Yes / No |

Consent for Procedure

I, (print name) _____, do hereby consent to authorize the application of Extracorporeal Shockwave Therapy (ESWT) for my condition listed above.

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

I am also aware of the risks of ESWT listed below.

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

Signed _____ **Date:** _____



Office Policies for SoftWave Therapy

At Parent Chiropractic Center we are committed to providing you and your family with the best care possible in a caring environment, and have established our financial and health insurance policies to achieve that goal.

HIPPA / Privacy Practices – I acknowledge that I have been given the opportunity to view the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Our office will use e-mail to inform you of any changes in our office hours, closings, education etc. In the event of a missed appointment, we will call the phone number provided to us.

Payment - Full payment is expected at the time of your visit for services rendered at each appointment. Any account that has a balance over 90 days will be automatically charged with the credit card that is required to be kept on file. There will be a \$35.00 fee for returned checks.

Past Due Accounts - We make every effort to avoid using a collection agency to settle an account. However, in the event that an account is over 90 days past due, and all attempts to collect the debt have gone unanswered, you will be responsible for the outstanding amount due in addition to any fees that the collection agency charges to collect the outstanding debt.

Release of Medical Records – I give permission for Dr. Parent to request medical information from other medical facilities that may help the doctor to accurately assess and treat my condition.

Missed Visit Policy – It is important that you arrive on time for your scheduled appointment. In the event that you need to cancel or reschedule your appointment, we kindly ask that you call our office 24 hours in advance.

Our office charges a \$50.00 missed visit fee if you do not show for your scheduled appointment.

Health Insurance: SoftWave therapy treatments are **NOT** billed to any health insurance companies.

I have read and understand each of the above mentioned office policies, please sign below.

Patient signature

Date