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. ____

____

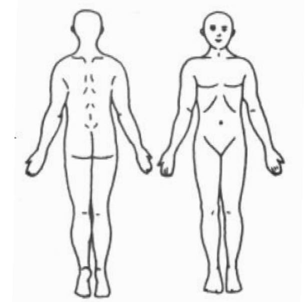
When did the problem(s) begin? ____________________ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

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 = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching
N = **N**umbness **S** = **S**harp/**S**tabbing **T** = **T**ingling

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** ____ **unbearable**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL pain? **No pain** ____ **unbearable**

0 1 2 3 4 5 6 7 8 9 10

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: _________

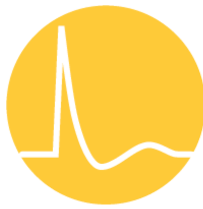
VISA / MC / Discover / AMEX

____________________________________ _____ - _____ - _____

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

Name: ______________________________________ DOB: __________________

Phone: _____________________ E-mail: _________________________________

Emergency contact Name: __________________________ relationship: __________

Emergency contact 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 in the last 21 days? Yes / No
- Do you have a cardiac pacemaker? Yes / No
- Do you have any active cancers / tumors? 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 18 years of age? Yes / No
- Do you have any known blood disorders? Yes / No
- Are you currently taking any blood-thining medication? Yes / No
- Do you have any autoimmune disorders? Yes / No
- Do you have a history of Tinnitus or ringing in the ears? 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 its purpose, benefits, and potential outcomes.
- I confirm that I have been given the opportunity to discuss and clarify any concerns and that no guarantees have been made to me regarding pain relief or improved function.

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 for cleared indications.

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