PARENT CHIROPRACTIC CENTER

SoftWave therapy

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

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

E-mail Address: _____(we use e-mail to keep you updated about office closures, change in hours due to holidays and weather, etc.)

Home Phone: _____ Mobile Phone:_____

REASON FOR VISIT

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

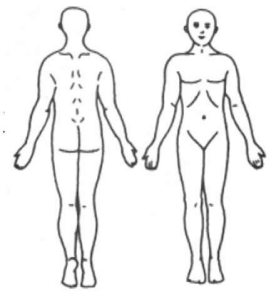
_____

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 = B**urning **D = D**ull **A =** Aching
N = Numbness **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 _____

_____

_____

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					
Driving a car					
Driving for long distances					
Riding as a passenger					
Riding for long distances					

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 that are not listed above:

_____

_____

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No
If yes whom: _____

2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____
_____

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

Extracorporeal Shockwave Therapy Patient Consent Form

Name: _____ Date: _____

DOB: _____ 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
- Do you have a history of blood clots/aneurysms? Yes / No

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

Consent for Procedure

I, (print name) _____, the Undersigned, do hereby consent to authorize the application of Extracorporeal Shockwave Therapy (ESWT) for my condition of: _____(**list condition below**)

_____

_____

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 also confirm 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.

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.

Social Media Release I agree to allow photos and video to be taken to be used for Parent Chiropractic Center and its social media platforms. I understand this information to be used to monitor my progress and may be used for research, marketing purposes and instructional purposes. I understand that all photos/videos may be edited to fit size, length and format limitations.

If you would **NOT** like to be videotaped, please initial here _____.

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

Patient signature Date