LINCOLN CHIROPRACTIC

EXTRACORPOREAL RADIAL SHOCKWAVE THERAPY CONSENT FORM

Patient Name: _____ Date: _____

Address: _____ Phone Number: _____

City: _____ Postal Code: _____

Email Address : _____

Did someone refer you? If so who? _____

Describe the major complaint (onset and duration) that brought you into our office.

_____

Have you had any other form of treatment ? Yes or No

If yes please describe: _____

Please list any prescription or non prescription drugs that you are taking at this time:

_____

Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of? _____

Please list hospitalization or surgeries you have had: _____

Are there any other health conditions we should know about?

_____

Please review the following contraindications and check those which apply for you:

- ☐ Coagulation Disorders, Thrombosis, Heart or Circulatory Patients
- ☐ Use of Anticoagulants, Especially Marcumar, Heparin, Coumadin
- ☐ Tumour Diseases, Carcinoma, Cancer Patients
- ☐ Pregnancy
- ☐ Polyneuropathy in case of diabetes
- ☐ Acute Inflammations / Pus focus in the target arena
- ☐ Children in growth
- ☐ Cortisone therapy up to 6 weeks before first treatment

POSSIBLE SIDE EFFECTS:

Swelling, reddening, hematoma's, pain, skin lesions after previous cortisone therapy

The side effects generally abate after 5 to 10 Days. Pain can increase temporarily. Bruising and or swelling are also possible.

I agree to Extracorporporeal Shockwave Therapy and understand the risks and possible complications involved.

Name: _____ **Date:** _____

Signature : _____