About the Patient

Personal Information

First Name
-

Last Name
-

Street Address 1
-

City
-

State/Province
-

Zip Code
-

Email
-

Phone
-

Date of Birth
-

Occupation
-

Reason for this Visit

Appointment Information

Is the purpose of this appointment related to
-

Primary Complaint(s)
-

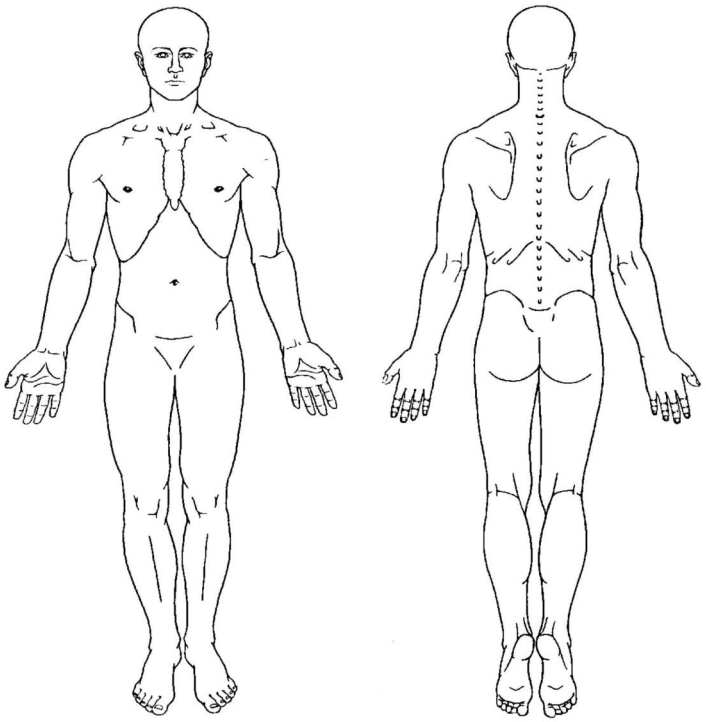
When did this condition begin?
-

Has this condition
-

Has this condition occurred before?
-

Place an X on the image below, where you feel pain, numbness, or tingling:

Mark your Pain Point



Missed Appointments

We strive to provide you with the utmost professionalism and excellence of service. Our commitment to your well-being and health is something we take seriously.
We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need and to the actions we recommend to you.
Your faithfulness to the recommended number of adjustments is key to ensuring optimum results.

- With the exception of emergencies, it is vital that you keep all your appointments. Reminder texts are provided to help you save the date. If you need to re-schedule an appointment, please call/text our office and arrange for a make-up appointment. We would prefer the make up appointment to be within the same week. Any appointments cancelled/rescheduled same day may be subject to a fee as missed appointments result in lost time that could have been used to provide care to other patients.
- In the instance of a no show without notice or less than 24 hours notice we reserve the right to charge you a $25.00 fee using a credit card we have on file.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

I understand and agree to all the information written above.

SoftWave Informed Consent

General Questions

Do you have any cancer, tumors, or skin lesions?

○ YES ○ NO

Are you using a cardiac pacemaker or implantable medical device?

○ YES ○ NO

Are you pregnant?

○ YES ○ NO

Tissue Regenerative Therapy (TRT)

Do you have a severe bleeding disorder/tendency?

○ YES ○ NO

Are you on NSAIDs or anticoagulant treatment?

○ YES ○ NO

Have you been injected with cortisone within the last 30 days?

○ YES ○ NO

Do you have a complete tear in the tendon?

○ YES ○ NO

Signature

Date Signed
-

Printed Name
-

Email
-

SoftWave Patient Quality of Life Survey

Patient Information

Please take several minutes to answer the following 12 questions so we can help you feel better.

Please check as many as apply.

1. How have you taken care of your health in the past?

☐ Medications ☐ Exercise ☐ Vitamins ☐ Emergency Room
☐ Nutrition/Diet ☐ Chiropractic ☐ Routine Medical ☐ Holistic Care
☐ Other (please specify)

2. How did the previous method(s) work out for you?

☐ Bad Results ☐ Great Results ☐ Did Not Get Worse
☐ Still Trying ☐ Some Results ☐ Nothing Changed
☐ Did Not Work Very Long ☐ Confused

3. How have others been affected by your health condition?

☐ No one is affected ☐ Haven't noticed any problem ☐ They tell me to do something
☐ People Avoid Me

4. What are you afraid this might be (or beginning) to affect (or will affect)?

☐ Job ☐ Marriage ☐ Time ☐ Kids ☐ Self-esteem ☐ Finances
☐ Future Ability ☐ Sleep ☐ Freedom

5. Are there health conditions you are afraid this might turn into?

☐ Family Health Problems ☐ Diabetes ☐ Depression
☐ Heart Disease ☐ Arthritis ☐ Chronic Fatigue
☐ Cancer ☐ Fibromyalgia ☐ Need Surgery

6. How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples.

-

7. What has that cost you (time,money,happiness,freedom,sleep,promotion,etc)? Please give three examples.

-

8. What are you most concerned with regarding your problem?

-

9. Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

-

10. What would be different/better without this problem? Please be specific

-

11. What do you desire most to get from working with us?

-

12. What would that mean to you?

-

The three TRT benefits will be explained by your doctor

RISKS: the following may occur due to treatment; local discomfort, soreness, bruising, increase in pain. During treatment, patients may experience minimal decrease in sensation, nausea, tingling, headaches, or fainting.

I have read or reviewed the above questions and read the warnings and contradictions. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment, and I have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to these treatments. I understand that there are no guarantees as to the success of my individual treatment and that individual treatments may vary from patient to patient.

Practice Member Information

Practice Member Name (Printed)

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DC Approval	Date
-	-