TRUE HEALTH
CHIROPRACTIC

Extracorporeal Shockwave Therapy Patient Consent Form

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Email: _____

Emergency Contact Name: _____ Relationship: _____
Emergency Contact 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
- Are you taking blood thinners? Yes / No
- Do you have a known blood clot? 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, _____, the Undersigned, do hereby consent to authorize the application of Extracorporeal Shockwave Therapy (ESWT) for my condition of

_____.

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: _____