



Patient Information

Patient Name: _____ Date: _____

Address: _____

Email Address: _____

Home #: (____) ____-____ Cell #: (____) ____-____

Sex: M F Age: ____ Date of Birth: __/__/____

Emergency Contact (Name, Relationship, Phone #): _____

Occupation: _____ Whom may we thank for referring you? _____

Family Health History: _____

Primary Care Physician: _____

Patient Condition

Reason for your visit? _____

When did it begin? _____ What do you think was the cause? _____

What makes it better? _____ Worse? _____

Rate the severity of the pain on a scale of 0 (no pain) to 10 (excruciating pain) 0 1 2 3 4 5 6 7 8 9 10

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning
Tingling Cramping Stiffness Swelling Other _____

Does this pain interfere with your Work Sleep Daily Routine Hobby/Recreation

Previous history of primary complaint? _____



StemWave Consent Form

By answering the following questions, you will assist our team in identifying if you are qualified to receive the application of today's treatment.

Areas of concern you would like addressed and treated: _____

Describe type of pain/feeling in the concerned area: _____

What goals do you want to accomplish with treatment? _____

Are you pregnant? Yes No

Do you have cancer/tumor or a skin infection? Yes No

Are you UNDER the age of 16? Yes No

Do you have a tear in the tendon? Yes No

Do you have a cardiac pacemaker? Yes No

Do you have a bleeding disorder/tendency to bleed? Yes No

Are you on NSAIDS, OPIOIDS or anti-coagulant treatment? Yes No

Have you received a cortisone injection within the last 30 days? Yes No

Have you had any imaging (X-Rays, MRIs) done on the area of concern? Yes No

→ if yes, what did you have done and where? _____

Medications: _____

Medical History: _____

Surgery History: _____

Accidents/Trauma: _____

RISKS OF PROCEDURE: There may be temporary pain &/or soreness. This typically resolves within hours or 1-2 days.

I, _____, (circle one: Patient / Legal Guardian) do hereby consent to authorize the application of today's treatment for the above stated issues. I fully understand the nature of today's treatment/procedure. I have researched the treatment option &/or the treatment has been fully explained to me by the treating physician/staff. I confirm that upon entering the facility I have been provided the opportunity to have a discussion to clarify any concerns I may have. I authorize that guaranteed results/expectations have not been promised to me. I also understand I am forgoing the opportunity for alternative &/or medical treatments and opting to have today's treatment per my personal discretion.

Signature: _____ Date: _____

Patient's Name _____

Date _____

OVERALL HEALTH HISTORY

Do you have vertigo (dizziness)?	YES _____	NO _____
Do you pass out easily (faint, loss of consciousness)?	YES _____	NO _____
Do you have double vision or have you lost sight in one eye?	YES _____	NO _____
Do you have any slurred speech or difficulty in arranging words properly?	YES _____	NO _____
Have you had any difficulty walking, with coordination or falling to one side?	YES _____	NO _____
Do you have any nausea or vomiting?	YES _____	NO _____
Do you have numbness on one side of you face or body?	YES _____	NO _____
Do you have any visual disturbances or rapid eye movement?	YES _____	NO _____
Do you have a headache or head pain that is unlike any you have had before?	YES _____	NO _____
Do you have headaches for hours or days?	YES _____	NO _____
Do you have history of stroke in the family?	YES _____	NO _____
Do you have chest pain?	YES _____	NO _____
Do you have any change in bowel or bladder habits?	YES _____	NO _____
Do you have a sore that does not heal?	YES _____	NO _____
Do you have any unusual bleeding or discharge?	YES _____	NO _____
Do you have any thickening in your breasts or elsewhere?	YES _____	NO _____
Do you have indigestion or difficulty swallowing?	YES _____	NO _____
Do you have a change in any wart or mole?	YES _____	NO _____
Do you have a nagging cough or hoarseness?	YES _____	NO _____
Do you have night sweats?	YES _____	NO _____
Do you have pain in the neck, jaw or face?	YES _____	NO _____
Do you have a drooping eyelid or changes in your pupils?	YES _____	NO _____
Do you have any ringing in your ears?	YES _____	NO _____
Do you take birth control pills?	YES _____	NO _____

PROBLEM SPECIFIC

Head: headaches y / n location _____

Neck: difficulty with: turning L—R—forward—backward—tilt right—tilt left

Midback: pain with cough, sneeze or bowel movement

Low Back: pain down the buttock—legs pain with cough sneeze or bowel movement

Shoulder: _____

Elbow: _____

Wrist: _____

Hand/Fingers: _____

Hip: _____

Knee: _____

Ankle: _____

Foot/Toes: _____



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AUTHORIZATION FOR RELEASE OF INFORMATION:

OFFICE USE ONLY

TO: _____

SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED:

_____ Medical Records regarding _____

_____ X-Rays and / or report of findings, CT scans, MRI's

_____ Consult reports from specialists

_____ Test Results

_____ Billing Records

_____ Other _____

I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.

Initials _____

I understand that this authorization is voluntary and that I may revoke it at anytime by submitting my revocation in writing to the entity providing the information. The revocation will only be effective from the date the written revocation is provided and will not apply retroactively.

Initials _____

I understand that this authorization will expire one (1) year from the date of the original signature indicated below.

Initials _____

Patient Name: _____ Date of Birth: _____

Signature of Patient _____ Date: _____

If under age 18 Signature of Guardian: _____ Date: _____

Relationship to Patient: _____