Glenmore Chiropractic Inc.

Shockwave Therapy

Is this a WorkSafeBC injury? □ Yes □No

If yes, please note that we do NOT deal with WorkSafeBC for billing.

Personal Information:

Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Primary Phone #:_____ E-mail: _____

Date of Birth: _____ Gender: _____ Sex:_____

Phone of Emergency Contact:_____ Relationship:_____

Name of Emergency Contact:_____

Family Physician:_____ Personal Health Number:_____

Employer: _____ Occupation:_____

How did you hear about us?

□ The Courier □ Health Fair □ Social Media □ Google Search □ Website

□Other:_____

Please Note: We do not do phone reminders. Your email address will **ONLY** be used for sending appointment reminders or to advise of changes at the clinic or with your appointment, insurance claim, or claim/account status or follow up treatments. We will **NOT** share your email or any personal information with anyone. If you do not wish to receive email reminders, please check this box □

What is your main complaint?_____

How did this condition begin? □ Work Injury □ Sport Injury □ Auto Accident

□ Home Accident □ Chronic □Other:_____

How long have you suffered with this condition?_____

Have you experienced previous episodes of this condition? □ Yes □No

Has this condition: □ Gotten Worse □ Gotten Better □ Stayed Constant □ Come & Goes

□Other:_____

Character of the condition: □ Sharp □ Dull □ Burning □ Numbness □ Pins & Needles

□Other:_____

Aggravating factors: □ Sitting □ Standing □ Bending □ Lifting □ Walking □ Lying

□Other:_____

Relieving factors: □ Bed Rest □ Ice □ Bending □ Lifting □ Walking □ Lying

□Other:_____

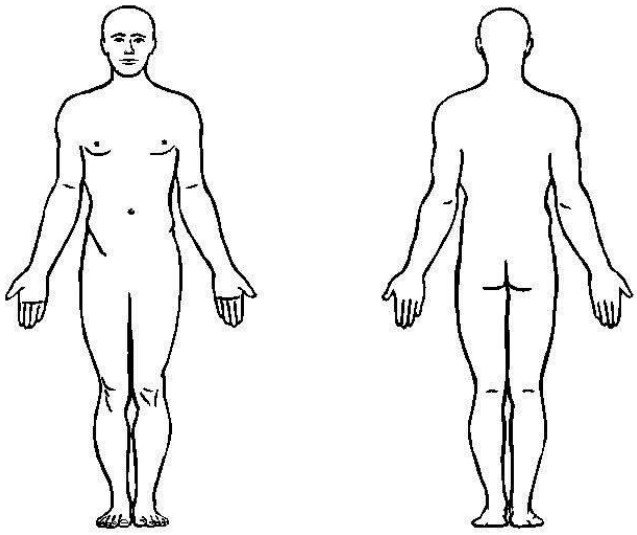
Does this condition interfere with: □ Work □ Family □ Sports/Hobbies

□Other:_____

What other types of treatments have you tried: □ Acupuncture □ Physiotherapy

□ Medication □ Massage □Other:_____

On the diagram below. Please circle the area(s) of your main complaint:



On the chart below, please circle the pain severityof your complaint (at its worst)

List any surgeries/medical procedures:_____

Please check any of the following you have had in the last 6 months:

- ☐ Cortisone Therapy
- ☐ Heart Problems
- ☐ Irregular Blood Pressure
- ☐ Pacemaker
- ☐ Acute Inflammation
- ☐ Cancer
- ☐ Tumor Disease, Carcinoma Patient
- ☐ Blood Thinning Medications (e.g., Marcumar)
- ☐ Diabetes

Other (please explain):_____

Are you pregnant? □ Yes □No If yes, how many weeks?_____

Please review and sign the consent for treatment **in front of the doctor** at your first appointment.

Informed Consent for Shockwave Therapy Treatment

Shockwave can trigger an inflammatory response which is the body's natural process of healing, for this reason do not use any anti-inflammatory medications or use heat or ice. If experiencing any pain, this should subside within 24hrs. To help with the pain you can take Advil or Tylenol, if necessary. Although the short-term effects alone are exceptional, the long term benefits of this treatment may take up to 3 to 4 months. Even if it feels good, we recommend decreased activity for 48hrs following the treatment. Possible side effects: Swelling, reddening, hematomas, petechiae, pain, skin lesions after cortisone therapy. These side effects generally abate after 5-10 days

Date: _____ Patient Signature _____

Doctor Signature _____