Date: ___/___/_____

Softwave Intake Form

Name_____ Gender: Male/Female
Preferred Name/Nickname_____ Date of Birth____/_____/_____ Age_____
Address_____City_____State_____Zip_____
Parent/Guardian(s) if minor: _____
Primary Phone _____ Cell/Home/Work Secondary Phone _____ Cell/Home/Work
Email Address _____
Occupation _____ Employer _____
Single / Married / Divorced / Widowed / Minor Spouse's/Significant Other Name _____
Number of Children (or siblings if minor)_____ Names, Ages, & Gender _____
_____
Who may we thank for referring you?_____

Emergency Contact

Please list the name of someone we can call in case of emergency – if your primary emergency contact (i.e. spouse or parent/guardian) is already receiving care at True North we will attempt to call them first but would like a secondary in the event we are unable to reach them.

Name of emergency contact: _____
Relationship of contact to you: _____
Phone number(s) for contact: _____
Preferred Hospital: GUNDERSEN MAYO OTHER:_____

Main Concern

What is your main area of concern for seeking softwave therapy? _____
Was there an accident/injury to this area that caused pain/symptoms? Yes / No
If yes, please explain: _____
_____
Are there any open auto or workman's compensation claims relating to these main concerns? □ Yes □ No
Are you receiving or have you received any other treatments for this condition? Yes / No
If yes please explain _____
_____

Please answer the following questions to determine if you will be a suitable candidate for ESWT (Extracorporeal Shockwave Therapy), also known as Softwave Tissue Regeneration Technologies.

- Do you have a latex allergy? Yes / No
- Do you have cancer / tumor? Yes / No
- Have you been injected with cortisone this month? Yes / No
- Are you using a cardiac pacemaker? 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 currently taking any NSAIDs (ibuprofen/tylenol/etc) or other pain medications? Yes / No

****IF YOU ANSWERED YES TO ANY OF THESE QUESTIONS, PLEASE CALL OUR OFFICE BEFORE YOUR VISIT TO DISCUSS YOUR ELIGIBILITY FOR SOFTWAVE TREATMENT!****

Name: _____ Date: ___/___/_____

Health History

List your top health concerns currently

1) _____ 2) _____ 3) _____ 4) _____

Are there any open auto or workman's compensation claims relating to these concerns? □ Yes □ No

List all over-the-counter & prescription medications you are on and the reason for each:

_____

_____

List any surgical operations & years:

_____

_____

List any injuries to your spine, minor or major, that the doctor should know about:

_____

Have you ever fractured or broken a bone? □ Yes □ No

If yes, please describe: _____

Other major traumas:

_____

_____

Please Check Any Issues You Have Had in the Past or Currently Have

___ Neck Pain	___ Scoliosis	___ Hearing Loss	___ High/Low Blood Pressure
___ Shoulder Pain	___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Nausea
___ Arm Pain	___ Headaches/Migraines	___ Dizziness	___ Digestive Issues
___ Back Pain	___ Frequent Colds/Ear Infections	___ Loss of Balance	___ GERD/Gastric Reflux
___ Sciatica	___ Sinus Issues	___ Epilepsy/Seizures	___ Diabetes
___ Hip/Leg Pain	___ Allergies	___ Stroke	___ Kidney Problems
___ Knee Pain	___ ADD/ADHD	___ Tremors	___ Bladder Problems
___ Foot Pain	___ Thyroid Issues	___ Asthma	___ Bedwetting
___ Numb/Tingling in extremities	___ Loss of Energy	___ Sleep Apnea	___ Menstrual Problems
___ Tight/Sore Muscles	___ Sleep Problems	___ Chest Pain	___ Prostate Problems
___ Fibromyalgia	___ Anxiety/Nervousness	___ Difficulty Breathing	___ Sexual Dysfunction
___ Poor Posture	___ Depression	___ Heart Problems	___ Infertility
___ Arthritis/Joint Pain	___ Double/Blurry Vision	___ Heart Attack	___ Cancer

Other conditions/diseases:

_____

_____

Name: _____ Date: ___/___/_____

Informed Consent for Softwave Therapy

The FDA has labeled this a “Non-Significant Risk” therapy. As a result of this therapy you may experience increased pain, soreness and/or bruising. This is temporary and should resolve after a few days. Any of these symptoms should be discussed with the therapy provider.

I do hereby consent to authorize the application of Extracorporeal Shockwave Therapy (ESWT) for my condition as discussed with the provider. I understand the benefits and risks associated with and the nature of ESWT. The use of such treatment for my specific condition will be discussed with me by the treating physician/staff before treatment is received. I also confirm that I am given the opportunity to discuss and clarify any concerns as they arise. I acknowledge that no guarantees have been made to me but this treatment is designed mainly for pain relief and may offer an improvement of function. I also understand that this treatment may not be the only option for my condition and an alternate treatment may be provided or offered to me.

Signature _____ Date: _____
(Parent Guardian if under 18)

X-Ray Authorization

As your healthcare provider, we are legally responsible for your health records. If it is necessary to take x-rays, we must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays. Please Note: The Doctors of True North Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice. By signing below, you are agreeing to the above terms and conditions.

Signature _____ Date: _____
(Parent Guardian if under 18)

FEMALE PRACTICE MEMBERS ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time the x-rays are taken at True North Chiropractic.

Signature _____ Date: _____
(Parent Guardian if under 18)

Notice of Privacy Practices Acknowledgement (HIPAA)

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:
1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician’s certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature _____ Date: _____
(Parent Guardian if under 18)

Name: _____ Date: ___/___/_____

Informed Consent for Chiropractic Care

The doctors may recommend chiropractic adjustments as part of your care. Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with Chiropractic care. The types of complications that have been reported secondary to Chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with Chiropractic care occurring at a rate between one instance per one million to one instance per two million cervical spine adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving Chiropractic care in the Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if Chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with Chiropractic care and give consent to the examination that the Doctor deems necessary and the Chiropractic care, including spinal adjustments, as reported following my assessment.
- I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.
- *If forms are for a minor:* I authorize the doctors and any and all True North Chiropractic team members to perform diagnostic procedures, radiographic evaluations, render Chiropractic care and perform Chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child without the permission of a spouse/former spouse or other guardian. If my authority to select and authorize care is revoked or altered, I will immediately notify True North Chiropractic.

Signature _____ Date: _____
(Parent Guardian if under 18)