TINA M. GOTTLIEB
CHIROPRACTIC

Extracorporeal Shockwave Therapy Patient Consent Form

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

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: _____

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Tina M. Gottlieb Chiropractic
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Temecula, CA 92591
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tina@drtinachiropractic.com
www.DrTinaChiropractic.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
○ No ○ Yes When?

Whom may we thank for referring you?

If so, whom?

Gender
○ Male ○ Female

Your Last Name

Your Social Security Number

Your First Name | Your Middle Name (or Initial) | Birth Date (MM/DD/YYYY)

Marital Status
○ Single ○ Married ○ Divorced
○ Widowed ○ Separated

Address

City | State/Province | ZIP/Postal Code | Home Phone | Spouse's Name

Email Address | Cell Phone | Child's Name and Age

Emergency Contact | Phone | Child's Name and Age

Your Occupation | Child's Name and Age

Your Employer

May we contact you at work?
○ Yes ○ No

Address

City | State/Province | ZIP/Postal Code | Work Phone

Insurance Carrier | Policy Number | Primary Care Provider's Name

Insured's Last Name | Birth Date (MM/DD/YYYY)

Who carries this policy?
○ Self ○ Spouse ○ Parent

First Name | Middle Name (or Initial)

Insured's Employer

Address

City | State/Province | ZIP/Postal Code | Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (darken circle): ○ An accident or injury
○ Work ○ Auto ○ Other _____
○ A *worsening long-term problem*
○ An interest in: ○ Wellness ○ Other _____

3. Onset (When did you first notice your current symptoms?)

_____

4. Intensity (How extreme are your current symptoms?)

0 ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 10
Absent Uncomfortable Agonizing

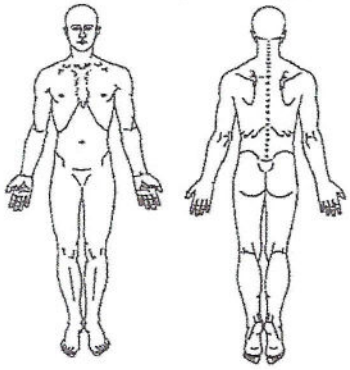
5. Duration and Timing (When did it start and how often do you feel it?)
○ Constant ○ Comes and goes. How Often? _____

_____

6. Quality of symptoms (What does it feel like?)

- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Dull
- ○ Aching
- ○ Cramps
- ○ Nagging
- ○ Sharp
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ Other _____

7. Location (*Where does it hurt?*)
Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past



8. Radiation (*Does it affect other areas of your body? To what areas does the* pain radiate, shoot or travel.)

_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

○ Prescription medication	○ Surgery	○ Ice
○ Over-the-counter drugs	○ Acupuncture	○ Heat
○ Homeopathic remedies	○ Chiropractic	Other _____
○ Physical therapy	○ Massage	_____

11. What else should Dr. Gottlieb know about your current condition? _____

_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture

NONE ○ Initials _____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness

NONE ○ Initials _____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising

NONE ○ Initials _____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia

NONE ○ Initials _____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	*Food sensitivities*	○	○	*Heartburn*	○	○	*Constipation*	○	○	*Diarrhea*

NONE ○ Initials _____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste

NONE ○ Initials _____

g. Integumentary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash

NONE ○ Initials _____

Consultation Notes

Patient name _____

Doctor's Initials

Tina M. Gottlieb
Chiropractic

(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	Initials ____

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: ____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: ____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine ____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: ____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List:

○ ○ Medications (prescription and over-the-counter).

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

FAMILY

18. Family History

Some health issues are hereditary. Tell Dr. Gottlieb about the health of your immediate family members.

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	____	○	○	____	____	○	○
Father	____	○	○	____	____	○	○
Sister 1	____	○	○	____	____	○	○
Sister 2	____	○	○	____	____	○	○
Brother 1	____	○	○	____	____	○	○
Brother 2	____	○	○	____	____	○	○
____	____	○	○	____	____	○	○

19. Are there any other hereditary health issues that you know about? ____

SOCIAL

20. Social History

Tell Dr. Gottlieb about your health habits and stress levels.

Alcohol use	○ Daily	○ Weekly	How much? ____
Coffee use	○ Daily	○ Weekly	How much? ____
Tobacco use	○ Daily	○ Weekly	How much? ____
Exercising	○ Daily	○ Weekly	How much? ____
Pain relievers	○ Daily	○ Weekly	How much? ____
Soft drinks	○ Daily	○ Weekly	How much? ____
Water intake	○ Daily	○ Weekly	How much? ____
Hobbies: ____			

Prayer or meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

Consultation Notes

Patient name

Doctor's Initials

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21. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? _____

23. How much sleep do you average per night? _____ **Hours**

24. What is the type and approximate age of your mattress and pillow? _____

25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: _____

_____ _____
Signature Date (MM/DD/YYYY)

Consultation Notes

Patient name

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Chiropractic

HIPAA

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

_____ _____

Please ***print*** name of Patient

Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian

Relationship of Legal Representative / Guardian

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____

I could not communicate with the patient ____

The patient refused to sign ____

The patient was unable to sign because ____

Other (please describe) _____

Signature of Privacy Officer

_____