

Please complete this intake form thoroughly to assist your OrthoWave provider in determining whether shockwave therapy is appropriate and safe for your condition. **All information is confidential and used solely for your clinical care.**

SECTION 1 — PATIENT INFORMATION

Full Name:		Date of Birth:	
Phone Number:		Email Address:	
Home Address:			
Emergency Contact:		Emergency Contact Phone:	
Date of Visit:		Referring Provider / Physician:	

SECTION 2 — CONDITION & PAIN INFORMATION

Tell us about what brings you in today

Primary area of pain / condition:			
Duration of condition:		Pain level today (0–10):	
Describe your symptoms in detail:			
What makes the condition worse?			
Previous treatments tried:			

QUESTION	YES	NO	IF YES — PLEASE EXPLAIN
Have you had surgery in this area?			
Are you currently under a physician's care for this condition?			
Have you had imaging (X-ray, MRI, ultrasound) for this?			
Have you received shockwave therapy before?			

SECTION 3 — MEDICAL HISTORY & CONTRAINDICATIONS

Required for your safety — please answer every item

■ ■ Important: The following conditions may affect whether OrthoWave shockwave therapy is safe for you. Please answer honestly. Your provider will review this section before treatment begins.

CONDITION	YES	NO	CONDITION	YES	NO
Pregnant or possibly pregnant			Pacemaker or implanted electronic device		
Active cancer or tumor			Blood clotting disorder		
Currently taking blood thinners			Recent steroid or cortisone injection		
Recent surgery (within 6 months)			Open wound or active infection		
Diabetes			Neuropathy or reduced pain sensation		
Metal implants near treatment area			History of seizures or epilepsy		
Severe osteoporosis			Autoimmune condition or active flare-up		
Severe peripheral vascular disease			Acute fracture in treatment area		

If YES to any above — please provide details:

SECTION 4 — CURRENT MEDICATIONS

Include all prescriptions, supplements, and vitamins

MEDICATION NAME	DOSAGE	REASON / CONDITION	HOW LONG

SECTION 5 — PATIENT ACKNOWLEDGEMENT & SIGNATURE

I certify that the information provided in this intake form is accurate and complete to the best of my knowledge. I understand that withholding or misrepresenting medical information may affect the safety and outcomes of my treatment. I authorize my OrthoWave provider to use this information for clinical assessment and treatment planning.

Patient Signature

Signature _____

Date: _____

Provider / Clinician Signature

Signature _____

Date: _____

Professional Clinical Use Only: This intake form is intended to assist OrthoWave providers in evaluating patients for shockwave therapy. Retain the signed original in the patient's medical record. Contact OrthoWave at **(770) 746-3322** or **theorthowave.com** for support.