SHOCKRx

Shockwave Therapy Specialists • Asheville, NC

PATIENT INTAKE FORM

Please complete all sections accurately. This information is kept strictly confidential.

SECTION 1 — PATIENT INFORMATION

Full Legal Name (Last, First, Middle) _____ **Date of Birth** _____ **Age** _____

Street Address _____ **City** _____ **State** _____ **ZIP Code** _____

Primary Phone _____ **Alternate Phone** _____ **Date of Service** _____

Email Address _____ **Preferred Contact Method ■ Phone ■ Text ■ Email** _____

Referring Physician / Provider (if applicable) _____ **Primary Care Physician** _____

SECTION 2 — EMERGENCY CONTACT

Emergency Contact Full Name _____ **Relationship to Patient** _____ **Phone Number** _____

Secondary Emergency Contact Name (optional) _____ **Relationship** _____ **Phone Number** _____

SECTION 3 — PAST MEDICAL HISTORY

Please check all conditions that apply or have applied to you:

■ Heart Disease / Heart Attack

■ High Blood Pressure (Hypertension)

■ Diabetes (Type 1 or Type 2)

■ Stroke / TIA

■ Arthritis (Osteo / Rheumatoid)

■ Fibromyalgia

■ Autoimmune Disorder

■ Thyroid Disorder

■ Kidney Disease

■ Liver Disease

■ Lung / Respiratory Disease

■ Neurological Disorder

■ Epilepsy / Seizure Disorder

■ Depression / Anxiety / Mental Health

■ History of Cancer / Malignancy

■ Blood Disorder / Hemophilia

■ Osteoporosis / Osteopenia

■ Peripheral Neuropathy

■ HIV / AIDS

■ Other: _____

■ Open Growth Plates (adolescents)

■ Deep Vein Thrombosis (DVT)

■ Hepatitis B or C

■ Other: _____

SECTION 4 — CURRENT MEDICATIONS & SUPPLEMENTS

List ALL current medications, vitamins, and supplements (include over-the-counter):

Medication Name	Dosage	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any known drug allergies? ■ No ■ Yes — If yes, please list:

Allergies / Reactions

_____

SECTION 5 — SHOCKWAVE THERAPY CONTRAINDICATIONS

IMPORTANT: Shockwave therapy is contraindicated in certain conditions. Please carefully review and check YES or NO for each item below. If you check YES to any item, please inform your provider immediately as treatment may need to be modified or postponed.

Contraindication	YES	NO
Blood clotting disorders or anticoagulant therapy (e.g., Warfarin, Xarelto, Eliquis)	■	■
Active infection, open wound, or skin lesion at or near the treatment site	■	■
Diagnosed malignancy / cancer (active or in remission — please specify below)	■	■
Current or suspected pregnancy	■	■
Implanted pacemaker, defibrillator, or other electronic implanted device	■	■
History of or current thrombosis (blood clot) — DVT, PE, or similar	■	■
Corticosteroid injection at or near the treatment site within the past 6 weeks	■	■
Severe osteoporosis (physician-diagnosed)	■	■
Severe peripheral neuropathy affecting the treatment area	■	■
Children or adolescents with open / unfused growth plates	■	■
Implanted metal hardware, pins, or plates near the treatment site	■	■
History of spinal cord injury or disease near the treatment area	■	■

If YES to any above, please provide additional details:

SECTION 6 — REASON FOR VISIT & TREATMENT AREA

Primary Complaint / Diagnosis

Duration of Symptoms

Treatment Area(s)

Pain Level (0–10)

Previous treatments tried

Have you had shockwave therapy before? ■ No ■ Yes — If yes, when and where:

SECTION 7 — INFORMED CONSENT & RELEASE OF LIABILITY

PLEASE READ CAREFULLY BEFORE SIGNING

I, the undersigned patient (or legal guardian/authorized representative), hereby acknowledge and agree to the following:

1. Nature of Treatment. I understand that Extracorporeal Shockwave Therapy (ESWT) is a non-invasive procedure that uses acoustic sound waves to stimulate healing in musculoskeletal tissues. I have been given the opportunity to ask questions and have received satisfactory answers regarding the procedure, its intended purpose, potential benefits, and risks.

2. Voluntary Consent. I voluntarily consent to receive shockwave therapy services provided by ShockkRx and its staff. I understand that I may withdraw this consent at any time prior to or during treatment.

3. Potential Risks. I understand that shockwave therapy, while generally safe, may involve risks including but not limited to: temporary soreness, bruising, swelling, redness, numbness or tingling at the treatment site, and in rare cases, increased pain or skin injury. I accept these risks as part of the treatment process.

4. Accuracy of Information. I affirm that all health information I have provided on this intake form is complete and accurate to the best of my knowledge. I understand that failure to disclose relevant medical conditions, medications, or contraindications may affect my safety and the quality of my care, and I accept full responsibility for any omissions or inaccuracies in the information provided.

5. Release of Liability. In consideration of services rendered, I hereby release and hold harmless **ShockkRx**, its owners, operators, practitioners, employees, agents, and representatives (collectively "Released Parties") from any and all claims, liabilities, damages, costs, or expenses arising from or related to: (a) shockwave therapy services provided to me; (b) any adverse reactions, complications, or outcomes resulting from my failure to accurately disclose my medical history or contraindications; or (c) any pre-existing conditions that may be affected by treatment. This release does not apply to claims arising from gross negligence or willful misconduct by the Released Parties.

6. No Guarantee of Results. I understand that ShockkRx makes no guarantee of specific outcomes or results from shockwave therapy, and that individual results may vary.

7. Photography / Records. I consent to the creation and retention of clinical records, progress notes, and treatment documentation as required for my care. ■ I also consent to the use of de-identified photographs for educational or clinical quality purposes (optional — check to consent).

8. HIPAA Acknowledgment. I acknowledge receipt of ShockkRx's Notice of Privacy Practices describing how my protected health information may be used and disclosed.

By signing below, I confirm that I have read, understood, and agree to all of the terms set forth in this Informed Consent and Release of Liability.

Patient / Guardian Signature

Date

Printed Name

Relationship to Patient (if not self)

Provider / Witness Signature

Date