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Consent Form

Full Name ____________________ Date of Birth ____________________

Address ____________________ City/State/Zip Code ____________________

Phone Number ____________________ Email Address ____________________ Preferred Contact Method ____________________

Patient Consent: By ansering the following questions, you will assist our team in identifying if you are qualified to receive the application of today's treatment.

Are you pregnant?	Yes ☐	No ☐
Do you have cancer/tumor?	Yes ☐	No ☐
Do you have a skin infection?	Yes ☐	No ☐
Are you 16-years of age or younger?	Yes ☐	No ☐
Do you have a tear in the tendon?	Yes ☐	No ☐
Have you eaten within the last 2 hours?	Yes ☐	No ☐
Do you have any implanted medical devices near the treatment area (e.g., pacemaker)? If yes, please specifiy: ____________________	Yes ☐	No ☐
Do you have a bleeding disorder/tendency to bleed?	Yes ☐	No ☐
Are you on NSAIDS, OPIOIDS, or anti-coagulant treatment?	Yes ☐	No ☐
Have you received a cortisone injection within the last 30-days?	Yes ☐	No ☐

Specific Condition Information

1. Reason for Visit: ____________________
   What specific condition or pain are you seeking treatment for with StemWave®?

2. Duration of Condition: ____________________
   How long have you been experiencing this condition or pain?

3. Previous Treatments: ____________________

   ____
   Have you tried other treatments for this condition? If so, please list them and describe their effectiveness.

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Pain Assessment

For all areas where you experience pain, answer the following questions:

1. Describe your pain location(s): ______________________________

2. How long have you been experiencing this pain?

☐ Less than 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6 months-1 year ☐ 1-2 years ☐ More than 2 years

3. How would you describe the pain? *(check all that apply)*

☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Shooting ☐ Burning ☐ Tingling

☐ Other: ______________________________

4. What was the cause of the pain, if known?

☐ Injury ☐ Overuse ☐ Post-Surgery ☐ Other: ______________________________

5. Have you previously sought treatment for the pain? *(check all that apply)*

☐ Yes ☐ No ______________________________

If yes, please list treatments received (e.g., chiropractic care, physical therapy, surgical interventions, medications, injections)

6. Are you currently taking any medications for this pain?

☐ Yes ☐ No ______________________________

If yes, list medications

Pain Rating Assessment

1. Rate your pain intensity on a scale from 0 to 10:

0=No Pain, 10=Worst Pain Possible

Current Pain Level________ Pain at its worst________ Pain at its best________

2. How does the pain affect your daily activities?

☐ Minimal Impact ☐ Moderate Impact ☐ Severe Impact

____

Activities most affected (e.g., walking, sitting, sleeping)

3. How often do you experience the pain?

☐ Occasionally (1-2 times per week) ☐ Frequently (3-4 times per week) ☐ Constantly (daily)

Morning Pain ☐ None ☐ Mild ☐ Moderate ☐ Severe

Afternoon Pain ☐ None ☐ Mild ☐ Moderate ☐ Severe

Evening Pain ☐ None ☐ Mild ☐ Moderate ☐ Severe

Pain Duration ______________________________

minutes/hours per episode

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StemWave® Treatment Information

1. Knowledge of StemWave®:

a. How did you hear about StemWave® therapy?

____

____

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b. Have you had StemWave® treatments before? If so, when and for what condition?

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2. Goals of treatment:

a. What are your expectations and goals for StemWave® therapy?

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*RISKS OF PROCEDURE: There may be temporary pain &/or soreness.
This typically resolves within hours or 1-2 days.*

I, ______________________________(circle one: Patient / Legal Guardian), do hereby consent to authorize the application of today's treatment for the above-stated issues. I fully understand the nature of the treatment or procedure and confirm that I have either researched this treatment option or had it fully explained to me by the treating physician or staff. Upon entering the facility, I was provided the opportunity to discuss and clarify any concerns I may have.

I acknowledge that StemWave® is an elective therapy and that during the initial mapping, relief of symptoms or full resolution of my condition cannot be guaranteed. By choosing this treatment, I am forgoing the opportunity for alternative and/or medical treatments based on my personal discretion. also recognize that following all aftercare recommendations provided by my healthcare provider is crucial for optimizing results. I have had the opportunity to ask questions about the procedure, all of which have been answered to my satisfaction.

Signature: ______________________________ **Date:** _______________