

Consent Form

Full Name

Date of Birth

Address

City/State/Zip Code

Phone Number

Email Address

Preferred Contact Method

Patient Consent: By answering 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)?

Yes No

If yes, please specify: _____

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.

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

StemWave® Treatment Information

1. Knowledge of StemWave®:

a. How did you hear about StemWave® therapy?

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

2. Goals of treatment:

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

*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. I 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: _____