DO LIFE WELL
CHIROPRACTIC WELLNESS CENTER

Extracorporeal Shockwave Therapy Patient Consent Form

Suitability for ESWT (Extracorporeal Shockwave Therapy) also known as TRT and nicknamed "the stem cell machine" from the TV show The Doctors.

By answering the following questions, you will assist us to decide if you are suitable for ESWT.

- Do you have bleeding disorder / tendency? Yes / No
- Are you on NSAIDS or anti-coagulant treatment? Yes / No
- 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 tear in the tendon? Yes / No
- Do you have skin infection? Yes / No
- Are you pregnant? Yes / No

RISKS OF THIS PROCEDURE

a) Petechiae or mild bruising. This usually subsides without treatment.
b) Pain and soreness. This is temporary and resolves after a week.
c) Tendon rupture and nerve injury. This is avoided with treatment with lower energy levels and by avoiding the nerve.

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 focal ESWT which use has been fully explained to me by my treating physician/staff, and I fully understand the nature of this treatment. I also confirmed that I have been given the opportunity to discuss and clarify any concerns and that no guarantees have been made to me as to the result/outcome of the treatment.
I have been advised that the treatment with ESWT will be 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.

Patient or Guardian Signature: _____ Date _____

Staff Witness (Print Name) _____

Staff Witness Signature _____ Date _____