RADIAL WAVE THERAPY QUESTIONNAIRE

Patient Name: _____ Date: _____

The Chattanooga Intelect® RPW 2 employs radial pressure wave therapy to effectively address musculoskeletal conditions by delivering focused shockwaves to the affected area. This non-invasive treatment promotes pain relief by disrupting pain signals and enhancing circulation, which facilitates increased blood flow and reduces inflammation. Additionally, the therapy stimulates tissue regeneration and accelerates the healing process of tendons, ligaments, and muscles. Patients typically experience improved mobility and a reduction in pain levels, making it an integral component of their rehabilitation program. Treatment sessions are efficient and can be easily integrated into the patient's overall care plan.

What are your major complaints? ___ Neck Pain ___ Mid Back Pain ___ Low Back Pain ___ Shoulder Pain (right / left) ___ Elbow Pain (right / left) ___ Wrist Pain (right / left) ___ Hip Pain (right / left) ___ Knee Pain (right / left) ___ Ankle Pain (right / left) ___ Foot Pain (right / left) ___Other: _____

Please explain above complaints in your own words: _____

_____

_____

_____

Do you have any of the following conditions? (Please check all that apply)

- ☐ Acute injuries (e.g., fractures, tendon ruptures)
- ☐ Active infections
- ☐ Cancer (current or in remission)
- ☐ Blood clotting disorders (thrombosis, etc)
- ☐ Heart conditions (e.g., pacemaker, any cardiovascular issues)
- ☐ Skin conditions at the treatment site (e.g., rash, open wounds)
- ☐ Neurological disorders (e.g., epilepsy, neuropathy)
- ☐ Pregnancy
- ☐ Other (please specify): _____
- ☐ None of the above

Are you currently taking any medications?

- ☐ Yes
- ☐ No

If yes, please list (or provide on separate sheet if necessary):

_____

Have you had any previous surgeries in the area to be treated?

- ☐ Yes
- ☐ No

If yes, please describe:

_____

Have you previously undergone any other treatments for your condition?

- ☐ Yes
- ☐ No

If yes, please describe:

_____

How long have you been experiencing this condition?

- ☐ Less than 3 months
- ☐ 3-6 months
- ☐ 6-12 months
- ☐ More than 1 year

What treatments have you tried for this condition? (Please check all that apply)

- ☐ Physical therapy
- ☐ Medication
- ☐ Injections - Date of last injection: _____
- ☐ Surgery
- ☐ Other (please specify):

_____

Do you engage in regular physical activity?

- ☐ Yes
- ☐ No

If yes, please describe: _____

Do you smoke or use tobacco products?

- ☐ Yes
- ☐ No

Disclaimer for Radial Pressure Wave Therapy

Important Information: Radial pressure wave therapy is a treatment option designed to promote healing and alleviate pain in musculoskeletal conditions. While many patients report positive outcomes, individual results may vary based on a variety of factors, including the nature and severity of the condition, overall health, and adherence to recommended treatment protocols.

Potential Outcomes:
Positive Effects: Many patients experience significant pain relief, improved mobility, and enhanced quality of life following treatment.
Variable Results: Some patients may experience minimal or no improvement in symptoms.
Side Effects: As with any medical treatment, there may be side effects, including but not limited to:

- Temporary discomfort or pain at the treatment site
- Swelling or bruising
- Allergic reactions (in rare cases)
- Skin irritation

Not Suitable for Everyone:
Radial pressure wave therapy is not appropriate for individuals with certain contraindications.

Acknowledgment:
By proceeding with treatment, you acknowledge that you have read and understood this disclaimer, including the potential outcomes and risks associated with radial pressure wave therapy. You agree to discuss any concerns with your healthcare provider.

Patient Confirmation Statement

I, _____ (print name), confirm that I do not have any of the following conditions, nor am I currently taking any medications that could compromise the area to be treated. I also acknowledge that I am not affected by any conditions or treatments associated with these risks, including but not limited to:

- **Pregnancy**
- **Acute infections**
- **Cancer or tumors** (including malignant tumors or any other type of cancer)
- **Chemotherapy drugs**: Certain chemotherapy agents may hinder tissue healing or cause inflammation, making Radial Pressure Wave Therapy (RPWT) unsuitable during or immediately after chemotherapy treatment.
- **Open wounds or fractures**
- **Severe vascular disorders** (including thrombosis, poor circulation, or other blood flow issues)
- **Neurological disorders** affecting sensation or movement in the treatment area
- **Blood clotting disorders and/or medications** that affect clotting or increase bleeding risk (such as Warfarin [Coumadin], Heparin, Aspirin, Clopidogrel [Plavix], Dabigatran [Pradaxa], Rivaroxaban [Xarelto], and other direct oral anticoagulants [DOACs], as well as antiplatelet medications like Ticlopidine)
- **Non-steroidal anti-inflammatory drugs (NSAIDs)**: Medications like Ibuprofen, Naproxen, or Diclofenac, which can interfere with the body's inflammatory response necessary for healing and increase the risk of bruising or bleeding during treatment.
- **Corticosteroids**: Medications such as Prednisone, Dexamethasone, and others, which can impede tissue healing and may cause tissue breakdown, bruising, or delayed recovery when combined with RPWT.
- **Diuretics (water pills)**: Medications like Furosemide (Lasix) or other diuretics that alter fluid balance and potentially impact tissue healing.
- **Implants or prosthetics** in the treatment area
- **Heart disease**: Severe heart conditions or arrhythmias (including medications such as Digoxin, Amiodarone, or Beta-blockers that may affect circulation or tissue health).
- **Unhealed bone fractures** or fractures that are still in the process of healing.

I understand that failing to disclose any of the above conditions or medications may increase the risk of complications, and I accept full responsibility for any consequences that may arise from such omissions.

By signing this statement, I confirm that I have provided accurate and complete information to the best of my knowledge regarding my medical history and current health status, and I agree to undergo Radial Pressure Wave Therapy (RPWT) based on this confirmation.

Patient Signature: _____

Thank you for completing this questionnaire. Please return it to the healthcare provider for review.

Radial Pressure Wave Therapy (RPWT) Treatment Waiver and Release of Liability

I, _____ (print name), hereby acknowledge and consent to undergo Radial Pressure Wave Therapy (RPWT), also known as Extracorporeal Shock Wave Therapy (ESWT), as a treatment for my musculoskeletal condition. I understand that this treatment involves the application of high-energy shock waves to targeted areas of my body to promote healing, reduce pain, and improve function.

Informed Consent and Acknowledgment of Risks:

I have been informed by the treating practitioner of the nature and purpose of RPWT, and I have had the opportunity to ask questions about the procedure. I understand that while RPWT may be beneficial for my condition, there are inherent risks associated with any medical or therapeutic procedure, including but not limited to:

- Pain or discomfort during or after treatment.
- Bruising, swelling, redness, or tenderness in the treatment area.
- Temporary or minor skin irritation or reactions.
- Worsening of symptoms in the short term before improvement is seen (as with some forms of therapy).
- Rare complications such as nerve or tissue injury, bleeding, or worsening of pre-existing conditions.

Medical History Disclosure:

I confirm that I have provided accurate and complete information regarding my medical history, including any current medications, allergies, prior injuries, and any conditions that may affect the suitability of RPWT for me. I have disclosed any contraindications or conditions that might pose a risk during the treatment, including pregnancy, active infections, blood clotting disorders, heart disease, open wounds, neurological conditions, and any implanted medical devices in the treatment area.

I understand that failing to disclose pertinent information may increase the risk of complications, and I accept full responsibility for any consequences that arise from such omissions.

Acknowledgment of Practitioner's Role:

I acknowledge that the treating practitioner is providing RPWT based on my informed consent and the understanding that all necessary precautions have been taken, including a review of my medical history. The practitioner will take every reasonable precaution to minimize risks, but I understand that no medical treatment is entirely without risk.

Release of Liability:

By signing this waiver, I agree to release, indemnify, and hold harmless the practitioner, their staff, and any affiliated entities from any and all liability, claims, damages, or legal actions arising from any adverse effects, complications, or injuries that may occur as a result of undergoing Radial Pressure Wave Therapy. This includes, but is not limited to, any potential injury, side effect, or worsening of my condition associated with the treatment.

I acknowledge that I have read and fully understand the terms of this waiver, that I have had the opportunity to ask questions, and that I am voluntarily consenting to undergo Radial Pressure Wave Therapy.

Patient Signature: _____
Date: _____

Practitioner Signature: _____
Date: _____