OCWC Shockwave Therapy Intake

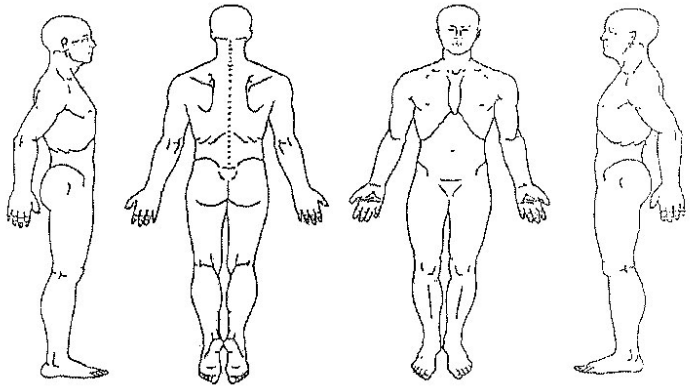
Confidential Patient Information

Patient Name: _____ Date: _____
Address: _____ City: _____Postal Code: _____
Phone Number: Primary_____ Secondary: _____
Email address:_____ Birth date:_____
Who referred you? _____
Describe the major complaint (onset and duration) that brought you into our office.

_____
_____
_____

Mark areas of complaint below

Numbness	N N N
Pins & Needles	P P P
Burning	X X X
Aching	A A A
Stabbing	/ / / /
Weakness	WW W



Have you had any other forms of treatment? Yes ⊙ No ○
If Yes, please describe: _____
Please list any prescription or non-prescription drugs that you are taking.
_____
Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of? _____
Please list any hospitalizations or surgeries you have had.
_____
Is there any other health condition that we should know about?
_____
_____

For office use

Additional Notes:
_____
_____
_____
_____
_____