HUTCHISON
Chiropractic Center

151 Mary Esther Blvd., Suite 301, Mary Esther, FL 32569

Phone: (850) 243-2723

SoftWave Therapy – New Patient Intake Form

Patient Name: _____

Date of Birth: _____ **Age:** _____

Phone: _____ **Email:** _____

Address: _____

City/State/Zip: _____

1. Reason for Visit

- What condition or area of pain/discomfort are you seeking treatment for?

- How long have you experienced this condition? _____
- Describe your pain (check all that apply): ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Numbness ☐ Tingling ☐ Other: _____

2. Pain Scale

On a scale of 0–10, please rate your pain:

- At rest: ____/10
- With activity: ____/10
- Worst: ____/10

3. Medical History

- Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, for what condition? _____

- List all current medications: _____

_____

- Past surgeries/injuries: _____
- Do you have any implanted medical devices (e.g., pacemaker, insulin pump)?

☐ Yes ☐ No If yes, please list: _____

- Women: Are you currently pregnant? ☐ Yes ☐ No

4. Contraindications Screening

SoftWave Therapy may not be recommended in certain situations. Please check if you have any of the following:

☐ Active cancer ☐ Open wounds ☐ Blood clotting disorders

☐ Use of anticoagulant medications ☐ Metal implants in treatment area

☐ Recent corticosteroid injections (within last 6 weeks)

☐ Other: _____

5. Lifestyle & Activity

- Occupation: _____
- Activity level: ☐ Sedentary ☐ Moderate ☐ Active ☐ Athlete
- Activities you are unable to perform due to pain: _____

6. Treatment Consent

I, the undersigned, consent to receive SoftWave Therapy as recommended by Hutchison Chiropractic Center. I understand the therapy involves the use of electrohydraulic acoustic waves and may cause mild discomfort, redness, or soreness following treatment. I have disclosed all relevant health information and understand I may withdraw my consent at any time.

Patient Name: _____ Date: _____

Signature: _____ Date: _____