



CLOUD 9 CHIROPRACTIC

PERSONAL CARE. MODERN POSSIBILITIES.

2116 Merrick Avenue, Suite 3009 | Merrick, NY 11566
(516) 665-3766

SoftWave patient intake

01 / PATIENT INFORMATION

Complete the fields on your computer, save a copy and bring it to your visit. For a handwritten signature, print the completed form and sign.
Select all applicable boxes unless instructed otherwise.

Last name	First name	MI
Birthdate	Date	Gender
Street address / apartment		
City	State	ZIP code
Cell phone	Home phone	
Email	Marital status	
Occupation	Employer	

Primary care provider

Primary care name	Primary care phone
Primary care address	

Referral & emergency contact

☐ Instagram	☐ Google	☐ Family / Friend	☐ Facebook
Emergency contact name	Relationship	Phone number	



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02 / SYMPTOMS & ACCIDENT INFORMATION

Accident information - void if not applicable

Accident date

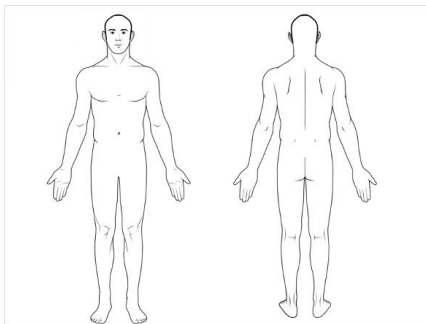
Reported to

☐ Auto accident

☐ Work accident

Attorney name (if applicable)

Where are you having pain or symptoms?



Describe location, side and symptoms below.

How often do you have your symptoms?

☐ Constant (76-100% of the time)

☐ Frequently (51-75% of the time)

☐ Occasionally (26-50% of the time)

☐ Sometimes (1-25% of the time)

How would you describe your symptoms?

☐ Dull

☐ Sharp

☐ Achy

☐ Burning

☐ Shooting

☐ Stiff

☐ Numb

☐ Tingling

☐ Sharp with motion

☐ Shooting with motion

☐ Stabbing with motion

☐ Electric with motion

How are the symptoms changing with time?

☐ Getting worse

☐ Stayed the same

☐ Improving

Problem rating: 0-10 (10 being the worst)



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03 / SYMPTOM HISTORY & SOFTWARE CONSENT

How do you think your problem began?

How long have you had your problem?

What makes your pain worse?

What makes your pain better?

Have you been treated for this discomfort? If so, what type of treatment?

Have you been to a Chiropractor before?

Extracorporeal Shockwave Therapy Patient Consent Form

Suitability for ESWT (Extracorporeal Shockwave Therapy), also known as Softwave Tissue Regeneration Technologies. By answering the following questions, you will assist us to decide if you are suitable for ESWT.

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 skin infection?

☐ Yes ☐ No

Are you pregnant or do you suspect you may be pregnant?

☐ Yes ☐ No

Are you under 16 years of age?

☐ Yes ☐ No



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04 / TREATMENT CONSENT & OFFICE AGREEMENTS

Risk of this procedure

Pain and soreness. This is temporary and resolves after a few days.

The FDA has labeled this a "Non-Significant Risk" therapy

Consent for procedure

I, the undersigned (full name)

Condition for which I authorize ESWT

I have been fully informed of ESWT which the use of has been fully explained to me by my treating physician/staff, and I fully understand the nature of this treatment. I also confirm that I have been given the opportunity to discuss and clarify any concerns and that no guarantees have been made to me 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.

Signed (type full name or sign after printing)

Date

Accuracy of information

☐ I certify that the above medical information is correct to my knowledge. Required

Privacy & sharing of information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree Required

Cancellation policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours' notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours' notice, or miss their appointment, will be charged a cancellation fee.

☐ I am aware of the Cancellation Policy. Required



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05 / CHIROPRACTIC RISKS & FINANCIAL AGREEMENT

Chiropractic adjustment / DRX9000 treatment risks

As with any healthcare procedure, there are certain complications which may arise during spinal manipulation and therapy. The most common complaints are of stiffness/soreness after adjustment and DRX9000 treatment. Some patients will feel some stiffness and soreness following the first few days of treatment. Cloud 9 will make every reasonable effort during the exam to screen for contraindications to care; however, if you have a condition which would otherwise not come to Cloud 9's attention, it is your responsibility to inform Cloud 9. A common treatment used by Doctor of Chiropractic's is spinal manipulative therapy: Cloud 9 may use hands on adjustments or a mechanical instrument to move specific joints. You may hear audible "clicks" or "pops", much as you would when you "crack" your knuckles. You may also feel a sense of movement.

☐ I am aware of the risks Required

Financial agreement

Services provided by Cloud 9 Chiropractic are not billable through your insurance provider; meaning Cloud 9 Chiropractic will not accept your insurance information and bill any patient charges for you through them. By eliminating this third party, it allows Cloud 9 to administer the treatment that is felt necessary for the patient's best interest. It is Cloud 9 Chiropractic's policy that payment is collected same day of service or prior to service if a pre-payment option has been elected. Cloud 9 Chiropractic accepts cash, checks and credit cards for payment. There is no refund.

☐ I Agree to this financial agreement Required

Signature (type full name or sign after printing)

Date