PATIENT HISTORY AND PRESCRIPTION REQUEST

CONTRAINDICATIONS FOR ARP THERAPY

Name:_____ Date of Birth: _____

Gender: (circle one) MALE FEMALE Phone Number:_____

Email Address: _____

How did you hear about EVO/ARP?:_____

Please Circle all present symptoms related to your condition:

Are you Pregnant? : YES NO

Do you have a pacemaker? : YES NO

Do you have a history of blood clots? : YES NO

TO HELP MEET YOUR NEEDS, PLEASE INDICATE YOUR SPECIFIC INTRERESTS:

When did your symptom/ complaints begin? _____

Describe your current symptom complaint: _____

_____

What was the cause of your symptom? _____

How have your symptoms progressed? _____

What other treatments have you done? (Circle all that apply)

Massage Medication Physical Therapy Surgery Chiropractic

Rest/Ice/compression

What activity bothers you the most?_____

What activity lessens your symptoms? _____

What does your pain feel like? (Circle) Burning Stabbing Aching Numbing Pins &Needles

Rate the intensity of pain: 1 2 3 4 5 6 7 8 9 10

Have you seen by another doctor for your current condition?

Please list all current medications:_____

Doctor's Name: _____ Phone _____

Result of visit_____

TRUTHFUL REPRESENTATION:

UPON SELECTION THE FOLLOWING BOX STATING "ALL INFORMATION IS TRUE" I HEREBY STATE THAT ALL THE INFORMATION I HAVE PROVIDED IS TRUE, CORRECT AND COMPLETE. IF MORE INFORMATION ABOUT MY CONDITION BECOMES KNOWN, I WILL TELL THE DOCTOR WHEN POSSIBLE SO THAT IT CAN BE ADDED TO MY RECORDS:

_____ ALL INFORMATION IS TRUE. (PLEASE INITIAL)

RELEASE OF LIABILITY:

IN CONJUNCTION WITH MY TREATMENT WITH ARP AT ARP WAVE CLINIC AND AS PART OF THE

CONSIDERATION FOR MY TREATMENT,I MY HEIRS EXECUTORS SPOUCE SUCCESSORS,ASSIGNS, OFFSPRINGAGENTS, AND REPRESENTATIVES EXPRESSLY RELEASE, HOLD HARMLESS,AND INDEMNIFY THE ARP WAVE CLINIC ITS OWNERS, AGENT EMPLOYEES, REPRESENTATIVES,ASSIGNEES, LICENSEES, AND INVITEES,FROM ALL LIABILIRY FOR ANY TREATMENTS GIVEN.

AFTER YOU HAVE ANSWERED ALL THE QUESTIONS ABOVE, PLEASE SIGN BELOW.

Signature_____Date_____