FAITH FAMILY CHIROPRACTIC, INC.

Dr. Javad Faith, D.C.
26302 La Paz Rd., Suite 215, Mission Viejo, CA 92691
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FOCUSED SHOCKWAVE THERAPY (fESWT) - INFORMED CONSENT

Patient Name		Date of Birth	
Area(s) to be treated		Treating Doctor	Dr. Javad Faith, D.C.

What is Focused Shockwave Therapy?

Focused extracorporeal shockwave therapy (fESWT) is a non-invasive treatment that delivers controlled acoustic pressure waves to a targeted musculoskeletal area. It may be used for selected tendon, muscle, ligament, fascial, joint, and related soft-tissue conditions.

Aims of Treatment

☐ Reduce pain

☐ Improve movement and function

☐ Improve tolerance for activity

☐ Support tissue repair and remodeling responses

☐ Improve local circulation

☐ Address chronic tissue irritation

☐ Improve tendon, muscle, or fascial function

☐ Other goal: _____

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FOCUSED SHOCKWAVE CONSENT - TREATMENT EXPERIENCE

What Treatment May Feel Like

Focused shockwave treatment is often uncomfortable and may be painful, particularly over a sensitive or injured area. Treatment intensity will be adjusted using my feedback and will be kept within a level that I consider reasonably tolerable.

☐ I may ask for the intensity to be reduced at any time.

☐ I may ask for treatment to be paused at any time.

☐ I may ask for treatment to be stopped completely at any time.

☐ I do not have to tolerate excessive pain for treatment to continue.

Possible Benefits

Possible benefits may include reduced pain, improved mobility, improved function, reduced stiffness or tenderness, and improved tolerance for activity. Improvement may be gradual and may require a series of treatments. No particular result, cure, or degree of improvement is guaranteed.

Common Temporary Reactions

☐ Soreness or aching

☐ Tenderness

☐ Temporary increase in symptoms

☐ Redness

☐ Mild swelling

☐ Bruising

☐ Increased sensitivity

☐ Fatigue

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FOCUSED SHOCKWAVE CONSENT - RISKS & SAFETY

Less Common Risks / Complications

Potential complications may include more significant bruising or hematoma, temporary numbness or tingling, nerve irritation, swelling, skin irritation, temporary worsening of pain, aggravation of an existing condition, or injury to blood vessels or surrounding soft tissue. Rare complications involving tendon or other tissue injury may occur. Not every possible complication can be predicted.

Please Tell the Doctor Before Treatment If Any Apply

☐ Pregnant or possibly pregnant

☐ Known or suspected tumor/cancer in treatment area

☐ Active infection in treatment area

☐ Bleeding or clotting disorder

☐ Blood thinner / anticoagulant use

☐ Pacemaker or implanted electronic device

☐ Severe vascular disease

☐ Significant nerve damage in treatment area

☐ Open wound in treatment area

☐ Recent surgery in treatment area

☐ Recent fracture

☐ Growing child/adolescent near a growth plate

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FOCUSED SHOCKWAVE CONSENT - FINAL ACKNOWLEDGMENT

Some conditions do not automatically prevent treatment, but may require modification, medical clearance, or avoidance of a particular area. Shockwave should not be directed toward certain sensitive structures such as brain, spinal cord, lung tissue, major blood vessels, active tumor tissue, a fetus, or growth plates in skeletally immature patients.

Alternatives

Depending on my condition, alternatives may include no treatment, activity modification, exercise or rehabilitation, chiropractic or manual care, physical therapy, medication or medical care, injection therapy, specialist evaluation, or surgery when appropriate.

Consent

I have been given the opportunity to ask questions. I understand the purpose and aims of focused shockwave therapy, the likelihood of discomfort or pain during treatment, possible benefits, common temporary reactions, material risks, reasonable alternatives, and that results are not guaranteed.

I understand that treatment will be adjusted using my feedback and that I may reduce the intensity, pause treatment, or stop treatment entirely at any time. I voluntarily consent to focused shockwave therapy.

Patient / Legal Representative Signature	_____	Date	_____
Printed Name	_____	Relationship (if applicable)	_____
Doctor Signature / Initials	_____	Date	_____