



Barrington Back & Body
CHIROPRACTIC & AESTHETIC REJUVENATION

Acousana™ Therapy Treatment Patient Info

(Patients, please complete top section only)

Patient's Name: _____
(First Name) (M.I.) (Last Name) (Suffix)

Birth Date: _____ Age: _____ Sex: M F SS#: _____

Home Mailing Address: _____ City: _____ State: _____ Zip: _____

Email Addresses (Home): _____ Work: _____

Phone Numbers (H): _____ (C): _____ (W): _____

Preferred Method of Contact: Home Email Work Email Home Address Home Phone Cell Phone Work Phone

Emergency Contact: _____ Relationship: _____ P: _____

Employment Status: Full-time Part-time Student Homemaker Unemployed Retired

Occupation: _____ Employer: _____

Job Requirements: Sit Stand Bend Lift Carry Travel Other: _____

Whom May we Thank For Referring You? Google Facebook Person: _____ Other: _____

Thank you, please return this form to the receptionist!

TRT Provider Initial Treatment Form

Complaints & Functional Assessment Pre-Treatment:

Patient's subjective and objective data reviewed and primary areas being considered for treatment are:

1. _____ VAS (_____/10)
2. _____ VAS (_____/10)
3. _____ VAS (_____/10)

Goals & Desired Functional Improvement Post-Treatment:

1. _____
2. _____
3. _____

ICD-10 Diagnosis: 1. _____ 2. _____ 3. _____ 4. _____



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Acousana™ Therapy Patient Consent Form

Suitability for Acousana™ Therapy and nicknamed “the stem cell machine” from the TV show The Doctors.

By answering the following questions, you will assist us to decide if you are suitable for Acousana™ Therapy.

- Do you have bleeding disorder/tendency? YES NO
- Are you on NSAIDS or anti-coagulant treatment? YES NO
- 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 tear in the tendon? YES NO
- Do you have skin infection? YES NO
- Are you pregnant? YES NO

RISKS OF THIS PROCEDURE

- a) Petechiae or mild bruising. This usually subsides without treatment.
- b) Pain and soreness. This is temporary and resolves after a week.
- c) Tendon rupture and nerve injury. This is avoided with treatment with lower energy levels and by avoiding the nerve.

Consent for Procedure:

I, _____, The Undersigned, do hereby consent to authorize the application of Acousana™ Therapy for my condition of _____.

I have been fully informed of focal Acousana™ Therapy which use has been fully explained to me by my treating physician/staff, and I fully understand the nature of this treatment. I also confirmed that I have been given the opportunity to discuss and clarify any concerns and that no guarantees have been made to me as to the result/outcome of the treatment. I have been advised that the treatment with Acousana™ Therapy will be 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 been provided or offered to me.

Patient or Guardian Signature: _____ **Date:** _____

Staff Witness (Print Name): _____

Staff Witness Signature: _____ **Date:** _____



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TRT OrthoGold 100™ Softwave Therapy

For Orthopedics & Sports Medicine

The non-invasive, pain-free, drug-free alternative to surgery

www.trtlc.com

OVERVIEW:

- TRT is short for “Tissue Regeneration Technology” which is state-of-the-art; non-invasive regenerative device that uses electro-hydraulically produced sound waves or acoustic waves to trigger a strong healing effect in the body. SoftWave™ therapy stimulates your body’s natural response for self-repair.
- Inside of the applicator head, SoftWaves™ are created through the use of an electrode contained within a soft latex dome filled with water. When charged with electricity, the electrode creates a spark under the water. This spark creates a hot bubble of gas that expands into the surrounding water and produces the SoftWave™ that travels out of the applicator and into the affected area being treated.
- These high energy acoustic waves penetrate deep into damaged tissue resulting in increased mobility and significant reduction, if not complete elimination of inflammation and pain in just the first treatment.
- Additionally, electro-hydraulically produced shockwaves have proven to have a 300% increase in small, medium, and large diameter blood vessels within 12 weeks following the first treatment.
- **These high energy acoustic waves cause cell walls to become permeable allowing exosomes (and other stem cell attractant chemicals) to escape into the interstitial tissue mimicking cellular injury which triggers the migration of the body’s own stem cells to the area.** This is why it was coined “The Stem Cell Machine” after being featured on the TV show “The Doctors” in November 2019.
- There are no known significant negative side effects.
- This treatment is 100% atraumatic to tissues and cells. It essentially “tricks” the body into thinking it’s been injured resulting in an activation of the body’s own healing response.
- Most patients only require 4-6 treatments per affected area spaced 5-7 days apart.
- There is no down-time, no anesthesia, no injections and generally no activity restrictions after treatment.
- Not all shockwave therapies are the same. This device is the only Unfocused Electro-hydraulic extracorporeal shock waves therapy (ESWT) available in North America and approved by the FDA.

MAIN EFFECTS OF SHOCKWAVE THERAPY:

- **Pain reduction**
- **Induces stem cells recruitment/migration to treated area**
- **Angiogenesis (new blood vessel formation)**
- **Reduces apoptosis (programmed cell death)**
- **Suppresses acute inflammation & modulates the inflammatory response**
- **Improves wound healing**
- **Induces neuronal regeneration (regeneration of peripheral nerves after injury)**

SUCCESS RATE:

The final outcome depends on a variety of factors, but most studies report a healing rate up to 85%. More than 80% of patients report improvement even after just one treatment. Depending on your condition you may require additional “booster” treatments in 2-3 months to maximize results. More severe or chronic degenerative conditions may take longer to heal, so be patient **and allow up to 12 weeks to evaluate your outcome as the biologic response and stem cell remodeling can be active up to 12 weeks after your final treatment and varies according to patient’s age and other comorbidities.** Lifestyle can also have a profound effect on healing outcomes.

AFTER CARE:

- It is not uncommon to be sore after your treatment, especially if you have severe degeneration or acute injury.
- Drink plenty of water after your treatments to help flush out inflammatory debris and reduce soreness.
- Stay compliant with your treatment recommendations.
- Avoid ice, heat, or anti-inflammatory medications for 24 hours after your treatment.
- DO NOT base success or failure on 1 treatment. SoftWave™ therapy is cumulative and healing takes time.

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Began When? ____/____/____ **Describe how this began:** _____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes (Describe) _____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both

Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both

Other Area: _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition? (Describe) _____

For this CURRENT condition, have you:

• **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: _____ **Where?** _____

• **Had any previous Surgery or Interventions in this area?** (Describe) _____

• **Taken any Medications?** OTC / Prescriptions _____

• **Had any diagnostic testing?** X-rays / MRI / CT / Other: _____ **When and Where?** _____

Describe any Secondary Complaints: _____

HEALTH HISTORY - (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

Medications:

Allergies to Medications: NONE (List) _____

Current Medications: NONE
(Already have a list? We can make a copy.) _____

Past Health History: (Please list any past...)

Surgeries - Date, Type, and Reason: NONE _____

Major Injuries/Traumas: NONE _____

Major Hospitalizations: NONE _____

Patient No: _____

Family Health History: (Please mark N/A if not relevant.)

List relevant major health problems of immediate relatives:

Deaths in immediate family: (Cause and at what Age?)

Social and Occupational History:

Level of Education Completed: _____

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: (Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)

Habits:

Cigarettes - (#/day) _____

Alcohol - (amount/day) _____

Coffee/Tea - (cups/day) _____

Rec. Drugs (List) _____

Are you currently experiencing any of these symptoms? (Check all the apply)
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: (constitutional)

- Recent Weight Change
Fever
Fatigue
None in this Category

Musculoskeletal:

- Low Back Pain
Mid Back Pain
Neck Pain
Arm Problems
Leg Problems
Painful Joints
Stiff/Swollen Joints
Sore/Weak Muscles or Joints
Muscle Spasms/Cramps
Broken Bones
Other:
None in this Category

Neurological:

- Numbness or tingling sensations
Loss of Feeling
Dizziness or light headed
Frequent or Recurrent Headaches
Convulsions or seizures
Tremors
Stroke
Have you ever had a head injury?
Ever been in an auto accident?
Other:
None in this Category

Mind/Stress:

- Nervousness
Depression
Sleep Problems
Memory Loss or Confusion
Other:
None in this Category

Genitourinary:

- Sexual Difficulty
Kidney Stones
Burning/Painful Urination
Change in force/strain w Urination
Frequent Urination
Blood in Urine
Incontinence or Bed Wetting
Other:
None in this Category

Gastrointestinal:

- Loss of Appetite
Blood in Stool
Change in Bowel Movements
Painful Bowel Movements
Nausea or Vomiting
Abdominal Pain
Frequent Diarrhea
Constipation
Other:
None in this Category

Cardiovascular & Heart:

- Chest Pains
Rapid or Heartbeat changes
Blood Pressure Problems
Swelling of Hands, Ankles, or Feet
Heart Problems
Other:
None in this Category

Respiratory:

- Difficulty Breathing
Persistent Cough
Coughing Blood
Asthma or Wheezing
Lung Problems
Other:
None in this Category

Eyes and Vision:

- Wear contacts/glasses
Blurred or double vision
Glaucoma
Eye disease or injury
Other:
None in this Category

Ears, Nose and Throat:

- Bleeding gums / mouth sores
Bad Breath or bad taste
Dental Problems
Swollen throat or voice change
Swollen glands in neck
Ringing in the ears
Ear - Ache/Ringing/Drainage
Sinus / Allergy problems
Nose Bleeds
Hearing Loss
Other:
None in this Category

Endocrine, Hematologic, and

Lymphatic:

- Thyroid problems
Diabetes
Excessive Thirst or urination
Cold Extremities
Heat or Cold intolerance
Change in hat or glove size
Dry skin
Glandular or hormone problem
Swollen Glands
Anemia
Easily Bruise or Bleed
Phlebitis
Transfusion
Immune system disorder
Other:
None in this Category

Skin and Breasts:

- Rash or Itching
Change in Skin Color
Change in hair or nails
Non-healing sores
Change of appearance of a mole
Breast Pain
Breast Lump
Breast Discharge
Other:
None in this Category

Women Only:

Are you pregnant?

- Yes - Due Date
No - Last Menstrual Period

- Infertility
Painful or Irregular periods
Vaginal Discharge
Other:
None in this Category

Pregnancies with Outcome & Date:

Comments:

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature Date

Treating Doctor Signature Date

Patient No:

Functional Rating Index

1. Pain Intensity

| | | | | |
|----------|-----------|---------------|-------------|------------|
| <u>0</u> | <u>1</u> | <u>2</u> | <u>3</u> | <u>4</u> |
| No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Pain |

2. Sleeping

| | | | | |
|----------|------------------|----------------------|-------------------|----------|
| <u>0</u> | <u>1</u> | <u>2</u> | <u>3</u> | <u>4</u> |
| Perfect | Mild Disturbance | Moderate Disturbance | Greatly Disturbed | No Sleep |

3. Personal Care (washing, dressing, etc.)

| | | | | |
|-----------------|----------------------------|-------------------|----------------------|----------------------|
| <u>0</u> | <u>1</u> | <u>2</u> | <u>3</u> | <u>4</u> |
| No Restrictions | Mild Pain; no restrictions | Need to go slowly | Need some assistance | Need 100% assistance |

4. Travel (driving, etc.)

| | | | | |
|---------------------|-----------------------|---------------------------|----------------------------|--------------------------|
| <u>0</u> | <u>1</u> | <u>2</u> | <u>3</u> | <u>4</u> |
| No Pain; Long trips | Mild Pain; Long trips | Moderate Pain; Long trips | Moderate Pain; Short trips | Severe Pain; Short trips |

5. Work

| | | | | |
|----------------------------|---------------------------|-------------------------|-------------------------|-------------|
| <u>0</u> | <u>1</u> | <u>2</u> | <u>3</u> | <u>4</u> |
| Usual Work; Plus unlimited | Usual Work; No Extra Work | 50% of Work; Usual Work | 25% of Work; Usual Work | Cannot Work |

6. Recreation

| | | | | |
|----------------|-----------------|-----------------|----------------|---------------|
| <u>0</u> | <u>1</u> | <u>2</u> | <u>3</u> | <u>4</u> |
| All Activities | Most Activities | Some Activities | Few Activities | No Activities |

7. Frequency of Pain

| | | | | |
|----------|----------------|----------------|----------------|----------------|
| <u>0</u> | <u>1</u> | <u>2</u> | <u>3</u> | <u>4</u> |
| No Pain | 25% of the day | 50% of the day | 75% of the day | All Day (100%) |

8. Lifting

| | | | | |
|-----------------------|------------------------------|---------------------------------|------------------------------|---------------------------|
| <u>0</u> | <u>1</u> | <u>2</u> | <u>3</u> | <u>4</u> |
| No Pain; Heavy weight | Increased Pain; Heavy weight | Increased Pain; Moderate weight | Increased Pain; Light weight | Increased Pain all weight |

9. Walking

| | | | | |
|-----------------------|------------------------------|------------------------------|------------------------------|----------------------------|
| <u>0</u> | <u>1</u> | <u>2</u> | <u>3</u> | <u>4</u> |
| No Pain; Any distance | Increased Pain; After 1 mile | Increased Pain; After ½ mile | Increased Pain; After ¼ mile | Increased Pain All walking |

10. Standing

| | | | | |
|------------------------|-------------------------------|------------------------|------------------------|------------------------------|
| <u>0</u> | <u>1</u> | <u>2</u> | <u>3</u> | <u>4</u> |
| No Pain; Several hours | Increased Pain; several hours | Increased Pain; 1 hour | Increased Pain; ½ hour | Increased Pain; any standing |

Name _____

Signature _____

Date _____