Kleinburg Family Health Centre
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Evaluation Form for Potential Patients of Radial Shockwave Therapy

Name: ___________________________

1. What area(s) do have pain? Please circle the area.

-Shoulder -Elbow -Hip -Knee -Shin -Ankle -Heel -Other___________________

2. Have you been given a diagnosis for your condition? Please circle the diagnosis.

- Rotator cuff tendonitis/calcific tendonitis
- Lateral epicondylitis (Tennis elbow)
- Trochanteric bursitis
- Patellar tendonitis (Jumper's knee)
- Tibial edge syndrome (Shin splints)
- Achilles tendonitis or tendonopathy
- Plantar fasciitis/heel spur
- Stress fractures
- Non-union of fractures

3. How long have you had this pain/condition? Please circle.

-Less than 3 months -Between 3 and 6 months -Between 6 months and 1 year -More than 1 year

4. Have you had this pain/condition in the past or is this your first episode?

-In the Past…When? _____________________ How many times? ___________________ -First Episode

5. Have you tried conservative physical therapy for your pain/condition? For example, therapeutic ultrasound, electrotherapy, laser, exercise therapy? Yes No

6. Have you had a cortisone injection for your pain/condition? Yes No

7. Have you been told by your doctor/therapist that you need surgery? Yes No

8. Have you had an x-ray or a diagnostic ultrasound or MRI for your pain/condition? Yes No

9. Are you willing and able to modify your activities of daily living for up to 12 weeks to get the full benefits of Radial Shockwave Therapy? Yes No

10. Are you able to attend therapy, 15 minutes per day, once a week, for 3 weeks? Yes No

11. Are you currently taking blood-thinning medication such as Heparin or Coumadin? Yes No

12. Are you pregnant? Yes No

13. Do you have cancer, diabetes, or significant heart or circulatory problems? Yes No

14. Please provide us with any other relevant medical history.

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