Thank you for your interest in Extracorporeal Shockwave Therapy or ESWT. The brief questionnaire form below will only take a few moments to complete. Any information you provided will be helpful in getting a better idea of you and your current condition.

First Name:

Last Name:

Company:

Address:

City:

State:

Zip Code:

Home Phone:

Work Phone:

Ext:

Email:

Preferred method of contact:
Home Phone
Work Phone
Email

How did you hear about ESWT?
Newspaper/magazine
TV/news
Doctor
Friend/relative
Web search
Mobile Truck
Other

If you selected “other”:

Have you seen a podiatrist or orthopedic physician for this condition?

If yes, what was the diagnosis of your condition?

Where did you feel the most pain?

Did this start as a result of an injury?
Yes
No

If yes, please describe injury:

On a scale of 0 being no pain to 10 being the worst, how would you rate your pain when it is at its worst?

Does anyone else in your family have the same problem?

What treatments have you tried on your own and/or with your doctor?

How does your condition interfere with your daily activities?

Do you have other painful areas due to walking funny (example: knees, back, hip pain, etc)?

Do you have insurance?
Yes
No

If yes what insurance company do you use?

Do you have any other questions for us or comments you would like to make?