



PhysioPod

CONTRAINDICATION FORM DEEP OSCILLATION®

The following information is required for your safety and to benefit your health. Whilst DEEP OSCILLATION® therapy is a very safe treatment, there are certain conditions, which may require special attention (any medical condition that prevent certain treatments from being given). The following information will be treated in the strictest confidence.

PERSONAL DETAILS

NAME

Date of Birth:

ADDRESS & TEL NO:

GP'S NAME, SURGERY & TEL NO:

Contraindications to DEEP OSCILLATION® therapy

Are you suffering from any of the following conditions? Please circle yes or no

- | | |
|---|--------|
| • Acute infection | YES/NO |
| • Infectious skin disease | YES/NO |
| • Active tuberculosis | YES/NO |
| • Untreated thromboses or vascular disorder | YES/NO |
| • Erysipelas or Cellulitis | YES/NO |
| • Untreated malignant diseases | YES/NO |
| • Untreated heart complaints or disease | YES/NO |
| • Cardiac pacemakers or other implanted stimulators | YES/NO |
| • Pregnancy | YES/NO |
| • Sensitivity to electrostatic fields | YES/NO |

Are you under the influence of alcohol or drugs? Yes/No

Do you permit photographs of the limb/area affected being taken before and after treatment and agree to their use on the PhysioPod website? Yes/No

Declaration: I hereby fully acknowledge that I am the above named client and fully understand all the questions contained in this questionnaire, I have answered every question truthfully and have no other medical condition or contraindication to treatment

PATIENT Signature

Date