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Scrambler Pain Therapy Relief Therapy
"Helping you get back into Life"
New Patient Information
(Please return via mail or fax)

Name ______________________________ Date of Birth ____________________ Gender M ❑ F ❑

Address ____

City ____ State ___________ Zip _________________

Email Address ____

Home Phone (____) ______________________________ Cell (______) ____________________________

Emergency Contact ____ Cell (____) __________________

Primary care physician ____

Primary Insurance ____ Ins. ID _____________________

Telephone (_____) ______________________________ Fax (_____) ___________________________

How did you hear about our clinic? ____

Where is your pain? ____

How long has your pain been present? ____

What is your average pain Score (1 – 10) _____________________

What medical evaluations / tests have you had for your pain? ___________________________________

____

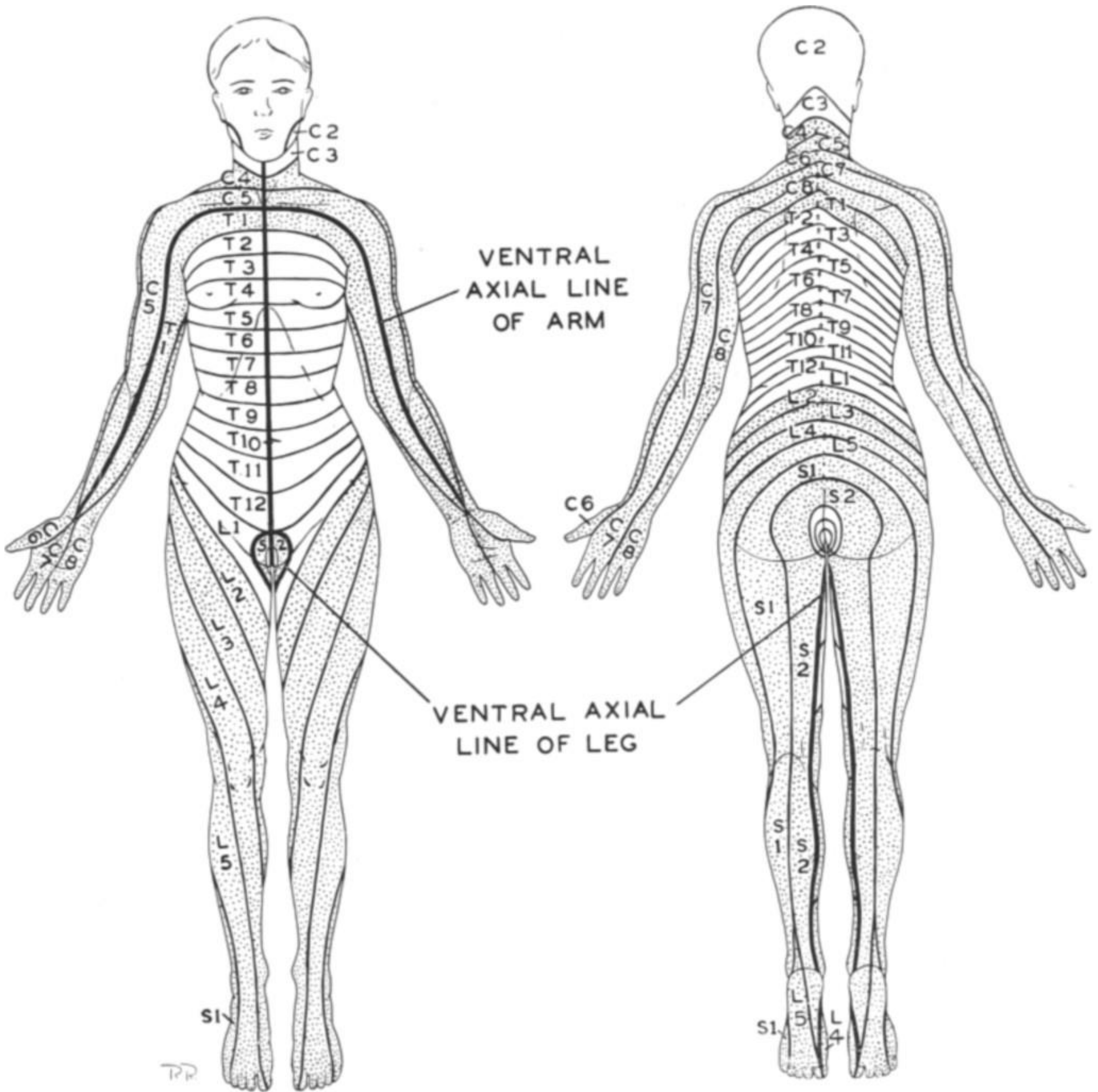
What treatments / therapies have you tried for your pain? ______________________________________

____

Have you had any surgeries for this pain? ____

List ALL MEDICATIONS AND DOSAGES you currently use for pain: ___________________________

____



Do you have a pacemaker or Defibrillator? Yes_____ No _____

Please highlight in YELLOW the area(s) of the body where you experience pain.
Please place a black **X** over the area of most severe pain.

Treatments

It is preferred that before Scrambler Therapy is begun, the patient be free of anticonvulsant medications or Marijuana/CBD oil. If the patient remains on these types of therapies, they will be instructed on a taper course and therapy may be extended by the number of days required for tapering off these substances. There is a list of some of the most common anticonvulsant medications at the end of this packet for your review.

To begin the process, all candidates for Scrambler Therapy will be evaluated by one of the medical providers at Gomez Neurology. This is to confirm this type of therapy is indicated and determine if needed, a suggested course to taper any of the anticonvulsant medications, Marijuana, or CBD. The patient, if approved, will then have their first session of Scrambler Therapy immediately after the medical consultation.

If the first session is well tolerated, the patient will be scheduled for the next 2 treatment sessions. Due to the need for consecutive day treatments, no new patients will be scheduled on Thursday or Friday of the week.

After the third session, the patient will be again examined by the medical provider to determine if continued Scrambler Therapy is again indicated. If this is the case, and the patient desires to continue the therapy the remainder of the 10 treatment sessions will be scheduled.

Not every patient will need all ten treatment sessions. However, we use this number as an average. Our standard treatment regimen is 5 treatment sessions a week for two consecutive weeks for a total of the 10 treatment sessions.

“Booster” Treatments

Please remember that every patient is unique. Depending on the severity of the patient's original condition and the length of time the patient has been experiencing chronic pain, booster treatments may be required to combat any return of pain.

In some cases, “booster treatments” can be extremely useful against any eventual recurrence of pain. The number of booster treatments needed can range from a single session to five or more. Patients who experience a recurrence of pain should document when the pain returns, subsides and what environmental issues were involved (stress, weather conditions, excessive use of the affected area) or if there was no specific cause for the elevation of pain.

Cost

Scrambler Pain Therapy Pain Relief Therapy (also called Scrambler Therapy) is a new therapy cleared by the FDA for use in the United States and provides a treatment option for those who suffer from chronic pain. We have priced the Scrambler Pain Therapy as affordable as possible. The cost per session is $275. Gomez Neurology accepts credit cards and financing is available through Care Credit.

By my signature below, I attest that the above information is true and accurate, and I am authorizing Dr. Francisco Gomez, Gomez Neurology, PLLC, or his agents, to perform whatever diagnostic procedures they may deem medically necessary in order to adequately evaluate and treat my condition (or patient's condition if I am the parent/legal guardian).

Signature:____ Date: ____________________

(Please return this form to Gomez Neurology via mail or fax)