EMS

HAVE YOUR SAY
ON YOUR SHOCKWAVE TREATMENT
We want to hear from you!

PLEASE COMPLETE THE FOLLOWING QUESTIONS AT THE CONCLUSION OF YOUR TREATMENT:

1. **How would you describe your overall experience with EMS Radial DolorClast® Shockwave Therapy?**

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Neither agree nor disagree
- ☐ Dissatisfied
- ☐ Very Dissatisfied

2. **Can you share specific details about the condition or issue you sought treatment for and why you or your practitioner chose EMS Radial DolorClast® Shockwave Therapy?**

Your issue:

Why you/your practitioner chose shockwave therapy:

3. **What improvements or changes have you noticed in your symptoms or overall well-being since undergoing EMS Radial DolorClast® Shockwave Therapy?**

4. **How did your experience with EMS Radial DolorClast® Shockwave Therapy compare to other treatments you may have tried in the past for the same condition?**

Please turn over

5 **How did the overall duration of your recovery compare to your expectations before undergoing EMS Radial DolorClast® Shockwave Therapy?**

6 **Would you recommend EMS Radial DolorClast® Shockwave Therapy to others experiencing similar conditions, and if so, why?**

Please select:

☐ Yes ☐ No

Why?

7 **Lastly, is there anything else you would like to share about your experience using EMS Radial DolorClast® Shockwave Therapy that could be helpful for others considering this treatment option?**

THANK YOU FOR SUBMITTING YOUR FEEDBACK!

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Practice Stamp

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