CALMARE® CERTIFIED | SCRAMBLER THERAPY NJ | USA

NEW PATIENT INFORMATION

CONFIDENTIAL PATIENT MEDICAL HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent record.

Name___John Canavari_____ Date of Birth _03/09/1959 Sex M √ F __

Address _330 West 72nd Street, 8A NY, NY 10023_____

City_____

State (US) _____ Zip (US) _____ Country _____

Contact Email ___jcanavari@hotmail.com_____

Home Phone _____

Cell __212-203-3734_____

Emergency Contact __Susan Canavari_____

Cell _347-401-1420_____

Are you currently employed? Yes No√ | Is the patient under age 18? Yes No

Patient Occupation__Retired_____ Employer _____

If under age 18, is the patient attending an on-site school at this time? Yes No

Are you: __Not disabled ___Completely disabled _√_Partially disabled Date of disability: _____

Are you reliant on any devices for normal mobility (cane, wheelchair, etc.): Yes √ No

Mobility device/s in use full-time or as-needed: __Cane_____

Marital Status __M√ _S __D__W Children & Ages _____

Spouse's Name __Susan Canavari_____ Cell_347-401-4120_____

Name / city/state of your personal care physician: __Dr David Lessman NYC 212-857-4524_

How else did you hear about Scrambler Therapy NJ? ___On-line research_Claude AI Engine_____

HIPAA POLICY

A notice of HIPAA health information practices is posted in our clinic waiting room for your review. If you have any questions, please inquire at the front desk.

I acknowledge that I have been informed of this policy and its location at 791 Passaic Ave., Clifton, NJ 07012,

Signature (patient or parent/legal guardian if patient is under age 18):

_____

Date: _____

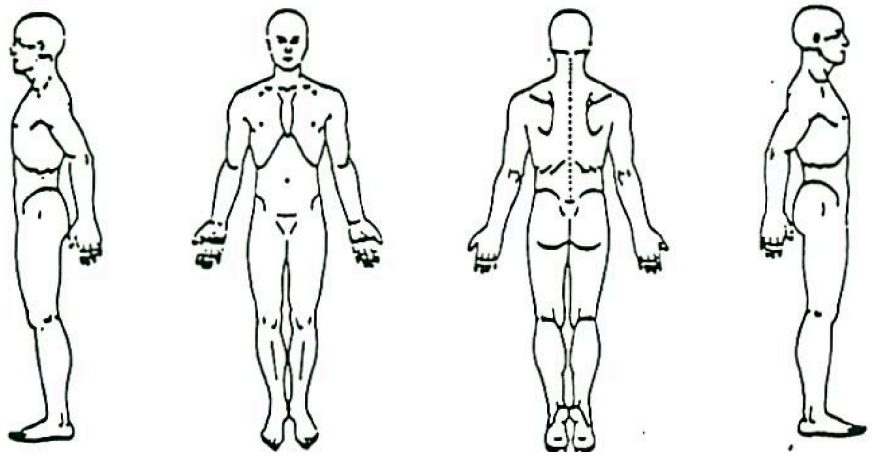
(Scroll down to next page)

NEUROPATHIC HISTORY

Please complete the following information as accurately as possible. All information will be held in strict confidence and never divulged to others without your prior authorization (or parent/guardian's authorization in the case of a minor).

Below: Mark the type and location of pain on the body outlines below. Use code letters as indicated:

Pain Drawing Key		
A= Ache	**P**= Pins & Needles	**S**= Stabbing
B= Burning	**X**= Other	**N**= Numbness



CURRENT PAIN SCALE: *(Mark your overall level or range of pain)*

No Pain (0) |----------|----------| (10) Worst Pain

Please identify cause (diagnosis) of chronic pain:

_Please see attached history of procedures since my pain began in September of 2000_____
_____
_____
_____.

How did your condition start? Include approximate dates of injury or surgery.
__My right knee was replaced in June of 2000 and walking for rehab a couple months later my low back pain began
_____
_____
_____.

Is your problem due to a work-related injury? ⛀Yes √⛀No
If yes, please describe:

_____
_____
_____

What doctors/health practitioners have you seen for this condition?

Doctor	Month/Year of Treatment	Treatment Prescribed
1. **Please attached history**		
2.		
3.		
4.		
5.		

Did your chronic pain begin:

⛀ Immediately after a specific incident/surgery* ⛀ After multiple incidents/surgeries*
⛀ Gradually over time ⛀ No specific reason noted

*Cite the incident/surgery/s:

_____
_____
_____

What makes your pain BETTER:

⛀ Lying down √⛀ Sitting ⛀ Standing ⛀ Walking ⛀ Movement/Exercise ⛀ Inactivity ⛀ Nothing ⛀ Other: _____

What makes your pain WORSE:

⛀ Lying down ⛀ Sitting ⛀√ Standing ⛀√ Walking ⛀ Movement/Exercise ⛀ Inactivity ⛀ Nothing ⛀ Other: _____

How often do you feel pain?

⛀ Constant (76-100%) ⛀√ Frequent (51-75%)
⛀ Occasional (26-50%) ⛀ Intermittent (25% or less)

Since your neuropathy began, the pain has:

⛀ Increased ⛀ Decreased **or** ⛀√ Has not Changed

How would you grade your overall daily stress level?

⛀ None ⛀ Minimal ⛀√ Moderate ⛀ Great

Does your pain interfere with your interpersonal relationships?

_____

0 1 2 3 4 5 6 7 8 9 √ 10
No Extremely

Does your pain interfere with your sleep?

_____

0 1 2 3 4 5 6 7 √ 8 9 10
No Extremely

Is your condition affecting your ability to work/ participate in normal daily activities?

If yes, please explain: ___Yes I've been forced to retire early_____
_____

ADDITIONAL MEDICAL CONDITIONS IN ADDITION CURRENT NEUROPATHY

(PAIN)? Yes / No

If yes, list other medical conditions: ____Just had 2 Left Shoulder replacement surgeries_____
_____
_____

EYE Issues Yes / No√
(blurred vision, eye pain, discharge, etc)
_____
_____

EARS, NOSE, THROAT, MOUTH Issues Yes / No√
_____
_____

RESPIRATORY Yes / No√
(asthma, emphysema, chronic bronchitis,
_____
_____

CARDIOVASCULAR Yes / No √
(diabetes, hypertension, heart problems)
_____
_____

GASTROINTESTIONAL Yes√ / No
(diarrhea, constipation, hernia, ulcers, etc.)
__GERD for many years Taking Omeprozole 40MG per day_____

GENITOURINARY Yes / No √

(painful urination, frequent urination, impotence, jaundice, etc.)

_____
_____

LYMPHATIC Yes / No √
(anemia, bleeding problems, problems with blood transfusions, etc.)

_____
_____

TOBACCO USE Yes / No √ (frequency)

_____

ALCOHOL USE Yes √ / No (frequency) ____Wine with dinner most nights_____

WOMEN ONLY – GYNECOLOGICAL ISSUES Yes / No
(Describe)

_____
_____

CURRENT MEDICATIONS AND DAILY PRESCRIBED DOSAGE:
Omprazole 40MG
Candesartan 16MG
Rosuvastatin 20MG
Amlodipine 5MG
Propranolol ER 120 MG

Zepbound (Tirzepatide/L -Carnitine) 15mg

1._____
2._____
3._____
4._____
5._____
6 _____
Additional: _____

Allergies

_____
_____

Family History (parents, siblings' diseases, chronic conditions, causes of early death)

_____
_____
_____
_____

Vitals (if known): Height: _**5'8"**__ Weight: _**204**____Typical BP: __**126/78**_____

What are your treatment goals by undergoing Scrambler Therapy? _Reduction/elimination of pain when I walk or stand…eventual return to exercise and an active life_____

Do you have any additional information you would like us to know?

I have tried many other types of therapies to reduce my pain including: Acupuncture, Structural Integration - Deep tissue work, EMDR - Eye movement desensitization and reprocessing, Ketamine infusions - 4, MAT - Muscle Activation Therapy, Ayurvedic Therapy - Herbal Supplements, Neuro Plasticity Therapy, PRT - Pain Reprocessing Therapy, Medical Marijuana, Coherent Breathing, Truvaga - Vagus Nerve Stimulator and Therapeutic Journaling - 6 months

I've also tried various meds including:
Ashwaganda - 300 mg/day
Pristiq SSNI
Valium / Diazepam
Duloxetine 80MG
Gabapentin 600 mg
Tramadol 50 mg
Lorazepam / Ativan .5mg

By my signature below, I attest that the above information is true and accurate:

Signature: _____

Date _____

TREATMENT AUTHORIZATION

I hereby acknowledge I am authorizing Dr. Jason Cooney, DC, and Dr. Michael Cooney, DC, Clinical Directors, Scrambler Therapy NJ USA, or their specified agent(s), to perform whatever diagnostic procedures they may deem medically necessary to adequately evaluate and treat my condition (or patient's condition, where I am the parent/legal guardian).

Patient Signature:

_____

Parent/Legal Guardian's Signature for Patients Under Age 18: Date:

_____ **_____**

File updated: 12.22.2025

CONSENT AND RELEASE FORM

By executing this Consent and Release, the undersigned knowingly and voluntarily consents to undergo Calmare® Scrambler Therapy, a pain treatment administered using the Calmare® Scrambler Therapy Medical Device. This therapy involves the application of surface electrodes that deliver low-level electrical impulses—sometimes referred to as “artificial neurons”—designed to interact with C-fiber nerves and modulate the transmission and perception of pain signals, thereby influencing how the body detects, interprets, and perceives pain and painful sensations.

The Calmare® medical device has Federal Food and Drug Administration (“FDA”) clearance for use in the United States.The Calmare scrambler therapy device has also received European Commission (EC) approval for use in Europe.

TREATMENT CONTRAINDICATIONS

Patients should not undergo the treatment if they have been diagnosed with any of the following contraindications or utilize these medical devices:

- Certain types of pacemakers, automatic defibrillators and other implanted devices.
- History of epilepsy, brain damage, use of anticonvulsant medications for purposes other than pain control.
- History or treatment for myocardial infarction or ischemic heart disease within the past six months.
- Actively pregnant. (Therapy can be performed post-partum.)

By voluntarily agreeing to receive treatment using the Calmare scrambler therapy medical device, you acknowledge and agree that such treatment is undertaken at your own risk, of your own free will, with full knowledge of the information set forth above, including the potential risks associated with the use of any medical device. You understand that individual responses to treatment may vary and that no guarantee of outcome or symptom relief has been promised, guaranteed or implied.

To the fullest extent permitted by law, you hereby release, discharge, and hold harmless the device manufacturer, Competitive Technologies, Inc. (also known as “CTTC” or “CTT”), Dr. Michael J. Cooney, DC, Dr. Jason G. Cooney, DC, and their respective affiliates, officers, directors, employees, agents, contractors, successors, and assigns (collectively, the “Released Parties”) from any and all claims, demands, causes of action, damages, losses, liabilities, injuries, conditions, illnesses, or other harm, whether known or unknown, that you may suffer or later alleged to have suffered arising out of, related to, or in connection with your use of the Medical Device or participation in Scrambler Therapy treatment, except to the extent prohibited by applicable law.

You further agree to waive any right to assert such claims against the Released Parties and covenant not to initiate or pursue any lawsuit, claim, or legal proceeding against the Released Parties relating to or arising from your use of the Medical Device or participation in the treatment.

Treatment outcomes are not guaranteed and may vary significantly depending on the individual, the presence of co-morbid conditions, and the duration, severity, and nature of the neuropathic pain condition being treated.

By signing this document below, and in addition to agreeing to all of the foregoing, you represent and warrant that you are at least eighteen (18) years of age, or otherwise legally authorized, and have the legal capacity to enter into a binding agreement.

You acknowledge that you have read and understand this Consent and Release in its entirety and that you voluntarily authorize and consent to receive Calmare® Scrambler Therapy treatment. Your signature below further acknowledges that you have been provided with sufficient information to make an informed decision and that you wish to proceed with the proposed treatment or procedure. You further acknowledge that you have had the opportunity to discuss the proposed treatment, including its risks, potential benefits, and available alternatives, as well as any questions or concerns, with your referring physician or other qualified health practitioner.

AUTHORIZED SIGNATURE

Adult Patient (18 or Older)

Print Name John Canavari_____ Patient Signature _____

Date _____

Minor Patient (Under 18 Years of Age)

Print Name of Minor Patient _____ Minor’s Date of Birth _____

Print Name of Parent or Legal Guardian _____ Relationship to Minor _____

Signature of Parent or Legal Guardian _____ Date _____ **(Updated 12.30.2025)**