



If you have been told that shockwave therapy might help your heel pain, tennis elbow, shoulder tendinopathy, or another stubborn soft tissue problem, the first question is usually simple: what actually happens during the appointment?

That question matters more than people think. When patients walk into a first session with a clear picture of the process, they tend to relax sooner, communicate better during treatment, and judge the early response more accurately. When they arrive with vague expectations, they often expect either a miracle in one visit or something far more dramatic than the reality. Most first sessions fall somewhere in the middle. They are usually straightforward, surprisingly short, and more interactive than many people expect.

Shockwave therapy is not a spa treatment, but it is not surgery either. It sits in that useful middle ground where a clinician is trying to stimulate healing and calm pain in tissue that has stopped recovering on its own. The appointment often feels technical, practical, and targeted. You lie down or sit in a treatment room, the clinician examines the painful area, uses a handheld device to deliver pulses into the tissue, checks your tolerance as the intensity builds, and then talks you through what to expect over the next few days.

That is the broad outline. The details are what make the experience easier.

Before the machine is even turned on

A good first shockwave therapy session rarely starts with treatment right away. It starts with confirmation that you are the right candidate.

That may sound obvious, but it is one of the most important parts of the visit. Pain in one spot does not always mean the problem is truly there. A patient might arrive convinced they have plantar fasciitis, for example, but the clinician may find a nerve issue, a calf loading problem, or pain coming from a different structure entirely. The same happens with shoulder pain, Achilles pain, and lateral elbow pain. If the diagnosis is off, the treatment misses the target.

Expect the clinician to ask about when the pain started, what makes it worse, whether it has changed recently, and what you have already tried. They may ask whether you have had imaging, but not every case requires it.

They will also want to know if you have conditions or circumstances that might affect whether shockwave therapy is appropriate. In practice, that could include pregnancy, bleeding disorders, the use of anticoagulant medication, certain nerve problems, active infection, or treatment over a known tumor site. Policies vary by clinic and condition, so the screening is important.

The physical exam is usually hands-on and specific. The clinician may press on the painful area, test your strength, check joint motion, and reproduce the movement or load that bothers you. This part can be more revealing than patients expect. Quite often, the exact tender point the device will target is identified during this exam, not from the referral note alone.

That first conversation also sets expectations. If a clinic tells you one session will definitely solve a chronic tendon problem, be cautious. In real practice, shockwave therapy often works as part of a broader plan, especially for issues that have been present for months. Many clinics recommend a series of sessions, commonly spaced about a week apart, though protocols vary.

Understanding what shockwave therapy is meant to do

The name sounds harsher than the treatment usually feels. Shockwave therapy uses acoustic waves, delivered through a handheld applicator, to stimulate a biological response in tissue that has become painful and slow to recover. Depending on the machine and the condition being treated, the goal may be to encourage circulation, disrupt chronic pain signaling, and promote a healing response in tendon, fascia, or other soft tissue.

Patients often confuse it with electrical stimulation because both involve a machine and a treatment head. It is not the same thing. You are not getting shocked in the everyday sense of the word. There is no sudden electric jolt traveling through your body. What you usually feel is a rapid series of mechanical pulses, more like repetitive tapping, pounding, or pressure.

That distinction matters because many first-time patients brace for something much worse than what they actually experience. A few minutes into treatment, most realize the discomfort is local, not alarming, and manageable when the intensity is adjusted properly.

The room, the setup, and the first few minutes

Most shockwave therapy sessions happen in a normal treatment room, not a hospital setting. The machine sits on a cart or counter, with a connected handpiece and controls the clinician can adjust throughout the session. The atmosphere is usually more like physical therapy, sports medicine, podiatry, or orthopedic rehab than a procedural suite.

You may be asked to expose the treatment area, which could mean rolling up a pant leg for Achilles or heel pain, wearing a sleeveless top for shoulder treatment, or positioning an arm on a pillow for elbow work. The clinician will then apply gel to the skin. That gel helps the acoustic waves transmit more effectively from the applicator into the tissue.

Positioning matters more than most people expect. If the target is the plantar fascia, you may lie face down or sit with the foot supported so the therapist can access the underside of the heel. For Achilles tendinopathy, the ankle may be placed in a relaxed position to expose the tendon clearly. For lateral elbow pain, the forearm may be turned so the tender tendon attachment is easy to locate. A small change in angle can make the treatment feel very different, both for comfort and effectiveness.

Before starting, the clinician often shows you the applicator, explains the sound it makes, and tells you how they plan to begin. Some devices click rapidly and loudly enough to surprise people the first time. That noise is

normal. It does not mean the intensity is high. Many patients say the sound is more intimidating than the actual sensation.

What the treatment feels like

This is the part everyone wants described plainly.

At the start, the clinician usually begins at a lower setting and delivers a few test pulses. The sensation ranges from firm tapping to deep, concentrated percussion. If the area is very inflamed or sensitive, it can feel sharp at first. If the tissue is thick and chronic, it may feel more like heavy pressure with a dull ache underneath. One patient with long-standing plantar fasciitis once described it as “someone knocking very quickly on a bruise.” That is not a perfect description, but it is close enough for many tendon and fascia cases.

The most accurate answer is that it depends on three things: the body part being treated, how irritated the tissue is, and how aggressively the settings are advanced. Heel and elbow complaints often feel quite focal. Shoulder treatment can feel broader and deeper. Achilles work can be tolerable one moment and spicy the next if the applicator moves onto the most tender portion of the tendon.

Discomfort during Shockwave Therapy is common, but there is a wide range between “noticeable” and “too much.” A skilled clinician watches that range carefully. In my experience, the best sessions are not the ones where the patient grits through maximum intensity. They are the ones where the dosage is strong enough to be therapeutically meaningful but still manageable. If your eyes are watering and your whole body is tensing, the setting may be too high for a first session, especially if the area is already highly reactive.

Most clinicians will ask for feedback while treating. That is not a courtesy question. It helps them adjust. Saying “that is tolerable,” “that spot is much sharper,” or “can we back off slightly” is useful information. Trying to act tough is not.

How long the session usually lasts

The actual application of shockwave often takes only a few minutes per area. The full visit, including assessment and setup, may last anywhere from about 15 to 30 minutes in many outpatient settings, sometimes longer if the initial examination is detailed or if the treatment is part of a broader rehab appointment.

The number of pulses and the energy level vary by condition and device. Some clinicians are very protocol-driven. Others adjust based on tissue response, location, and patient tolerance. That variability is normal. It does not automatically mean one clinic is doing it right and another is doing it wrong. It often reflects differences in equipment, training, and case selection.

For a first session, many clinicians are a bit more conservative. They want to see how your tissue responds over the next day or two rather than assuming you will tolerate an aggressive dose right away. Chronic, thickened tendon tissue in an athlete may be treated differently than a newly aggravated heel in someone who stands all day for work.

What you should wear and bring

The appointment is simple enough that you usually do not need to prepare much, but a few practical choices make it smoother.

- Wear clothing that gives easy access to the painful area.
- Bring any relevant imaging reports or referral notes if the clinic asked for them.

- Know what treatments you have already tried, including injections, orthotics, physical therapy, and medications.
- Be ready to describe your pain clearly, including the worst movements and the exact location.
- Avoid applying thick lotions to the treatment area right before the session.

Patients sometimes show up unable to remember whether they had a steroid injection two weeks ago or six months ago, or whether the pain is worst first thing in the morning or after activity. Those details matter because they shape both the diagnosis and the treatment plan.

What happens right after the pulses stop

Once the machine is off, the treated area may feel a little warm, heavy, numb, sore, or oddly relieved. Reactions differ. Some people stand up and say it feels looser immediately. Others feel no big change on the table and notice the effect later. A few feel more irritated for 24 to 48 hours before things settle.

That short-term soreness is one of the most common things patients misread. They assume soreness means the treatment made things worse. Often it simply means the tissue has been stimulated. The key question is whether the soreness is proportionate and temporary. Mild to moderate tenderness for a day or two is common. Severe escalating pain, marked swelling, or symptoms that feel clearly abnormal deserve a call to the clinic.

The clinician will usually give basic aftercare guidance. This is where clinics differ, but one principle is common: do not treat the area like nothing happened. A first session is not the day to test your foot with a long run, your elbow with heavy gripping work, or your Achilles with hill sprints. Relative rest is usually smarter than either full immobilization or immediate overuse.

Some clinicians advise avoiding anti-inflammatory medications around the treatment window, particularly if the goal is to encourage a healing response. That advice varies and should be individualized, especially if you take such medication for another condition. It is worth asking rather than assuming.

A realistic timeline for improvement

This is where expectation management matters most.

Shockwave therapy rarely behaves like an anesthetic injection where the change is obvious within hours because of a numbing effect. Some patients do notice early pain relief, but many do not feel meaningful improvement until after a couple of sessions, and some improve most noticeably several weeks after the treatment series is complete.

That delayed response can frustrate people who are used to evaluating a treatment by how they feel the same night. Tendon and fascia problems often do not work that way. If the tissue has been irritated for six months, a subtle shift after one week can still be a good sign. Better morning pain, less post-activity ache, improved tolerance for stairs, or less tenderness on first steps out of bed often shows up before dramatic gains.

In chronic plantar fasciitis, for example, one of the earliest wins is sometimes not “my heel is pain-free,” but “I no longer dread getting out of bed in the morning.” With lateral elbow pain, a patient may first notice that lifting a kettle or shaking hands hurts less before they can return to sport. These are meaningful changes, even if they are modest.

Why the first session is often part of a bigger plan

Shockwave therapy is frequently most useful when paired with a structured rehab strategy. That could include calf strengthening for Achilles issues, loading exercises for tendinopathy, foot mechanics work for plantar heel pain, shoulder programming, or simple activity modification while the tissue calms down.

This point is easy to overlook because the machine is the memorable part. Patients may think the device is doing *Shockwave Therapy* all the work. In reality, the treatment often helps create a better environment for progress, but the surrounding plan still matters. A person with insertional Achilles pain who keeps sprinting three times a week through high pain levels may not respond well even if the sessions are technically sound. On the other hand, a patient who combines treatment with sensible load management often gives the tissue a real chance to adapt.

If your clinician talks about shoes, training volume, work setup, mobility, or strengthening, that is usually a good sign. It means they are treating the problem, not just delivering a procedure.

Questions worth asking before you leave

A first session goes better when you leave with a practical sense of what comes next.

- How sore should I expect to be over the next 48 hours?
- Are there activities I should avoid until the next appointment?
- When should I expect to judge whether this is helping?
- How many sessions do you typically recommend for my condition?
- What should I do alongside treatment to improve the result?

Those questions tend to produce more useful answers than asking whether it will “work.” In musculoskeletal care, the better question is usually how progress will be measured and over what timeline.

When a first session feels easier or harder than expected

People often compare their experience with stories they read online, and that can be misleading. One person says shockwave was painless. Another says it was intense. Both may be telling the truth.

A first session tends to feel easier when the tissue is chronic but not highly reactive, the target area is not extremely sensitive, and the clinician builds intensity gradually. It can feel harder when the tendon or fascia is acutely irritated, the patient is anxious and tense, or the clinician goes after the most tender spot too quickly. Body region also matters. The underside of the heel can be particularly vivid because there is not much soft tissue padding there.

The emotional side is real too. Patients who know they can ask for minor adjustments usually do better than those who think they have to endure everything in silence. The treatment is not a test of toughness. It is a therapeutic intervention that should be dosed intelligently.

Signs that your provider is paying attention

One of the reassuring features of a good first session is that it feels individualized. The clinician should not simply glance at the referral, put gel on the painful area, and start firing pulses without discussion. Good care looks more deliberate than that.

They should confirm the diagnosis or at least the working diagnosis, explain the treatment briefly in understandable terms, locate the tissue carefully, adjust the dose based on your response, and tell you what the

next few days are likely to feel like. If they also connect the treatment to your overall rehab plan, even better.

That kind of session often leaves patients feeling informed even if they are a little sore. They know what happened, why it happened, and what to watch for next.

What not to expect from the first appointment

It helps to remove a few common misconceptions.

You should not expect the session to be completely sensation-free. Most people feel it distinctly. You also should not expect immediate, permanent pain relief after a single visit for a long-standing condition. That does happen occasionally, but it is not the benchmark to use. And you should not expect the machine alone to fix every problem if the diagnosis is unclear or the tissue keeps getting overloaded in daily life.

You also do not need to expect downtime in the dramatic sense. Most patients walk out on their own, return to work, and continue normal daily activities with a bit of common sense. The bigger issue is not incapacity. It is pacing. Do enough to stay moving, but not so much that you provoke the area while it is settling from treatment.

The takeaway from a first experience

For most people, the first shockwave therapy session is less mysterious and less intimidating than the name suggests. It is typically a focused appointment built around assessment, precise targeting, a few minutes of acoustic pulse treatment, and a practical recovery plan. The sensation can be uncomfortable, especially over a very tender spot, but it is usually brief and adjustable. The aftermath is often manageable, with mild soreness or tenderness more common than major disruption.

The bigger picture matters more than the drama of the machine. A useful first session gives you three things: confidence that the painful tissue has been identified correctly, a treatment dose matched to your tolerance, and a clear sense of what progress should look like over the next several weeks. When those pieces are in place, shockwave therapy tends to make much more sense, and patients can judge it by the right standard, not by whether one appointment produced instant results.

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FAQ About Shockwave Therapy

What does shockwave therapy actually do?

Shockwave therapy delivers high-energy acoustic sound waves through the skin to an injured area. This process "wakes up" stubborn, chronic soft-tissue injuries by increasing local blood flow, breaking down calcifications, and triggering the body's natural cellular repair and tissue regeneration mechanisms.

What are the drawbacks of shockwave therapy?

Shockwave therapy can cause temporary pain, skin redness, bruising, swelling, or numbness at the treatment site. It may require multiple sessions, can be costly out-of-pocket because insurance often does not cover it, and is unsafe for pregnant individuals or those with blood-clotting disorders.

Does shock wave therapy really work?

Yes, shock wave therapy (extracorporeal shockwave therapy, or ESWT) works well for specific chronic soft-tissue and bone conditions, showing success rates around 60% to 80% for stubborn issues like plantar fasciitis and tennis elbow when other conservative treatments fail.