PRE-TREATMENT ASSESSMENT

Patient Name: _____ Patient DOB:_____

Date of Assessment: _____Physician/Therapist Name:_____
(Print)

DIRECTIONS: Note + or – in each of the five circled areas showing ability (+) or inability (-) to sense a 5.07 Semmes-Weinstein Monofilament.

Right Foot

Left Foot

Pre-Treatment Evaluation Notes:

_____Start Date of Anodyne Treatments _____Time Per Treatment_____Bar Setting

No Pain **Worst pain**

Analog Pain Scale: 0 1 2 3 4 5 6 7 8 9 10 (Circle one)

Other objective and subjective measures related to patient complaints and functional limitations (pain, inability to sleep, exercise, ambulate) prior to using Anodyne.

_____

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_____

_____

_____

Signature _____**Date**_____

POST-TREATMENT ASSESSMENT

Patient Name: _____ Patient DOB:_____

Date of Assessment:: _____Physician/Therapist Name:_____
(Print)

DIRECTIONS: Note + or – in each of the five circled areas showing ability (+) or inability (-) to sense a 5.07 Semmes-Weinstein Monofilament.

Right Foot

Left Foot

Progress Notes:

_____Total Number of Anodyne Therapy Sessions _____End Date of Anodyne Therapy

No Pain **Worst pain**

Analog Pain Scale: 0 1 2 3 4 5 6 7 8 9 10 (Circle one)

Pain Meds Reduced:____Yes ____No **Sleeping Meds Reduced:** ____Yes ____No

Note objective and subjective changes or improvements in response to treatment protocol (i.e. ability to ambulate, sleep, exercise, etc.)

_____

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Signature _____**Date**_____