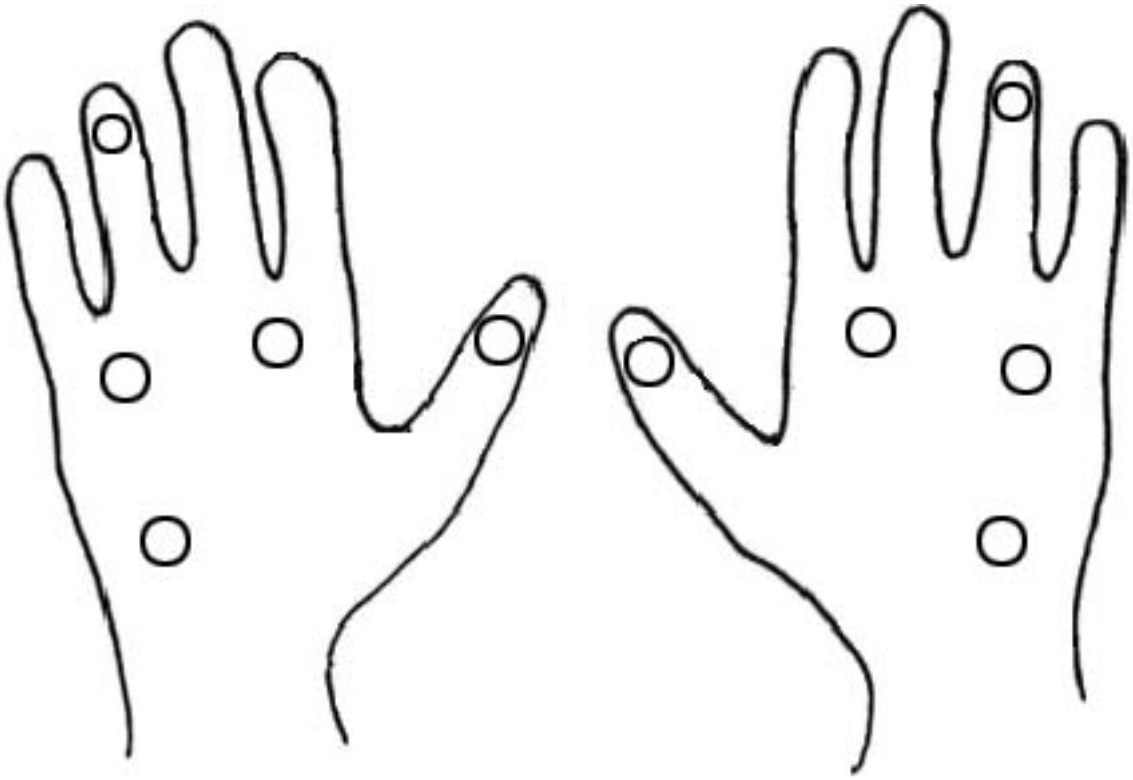
Hand Evaluation Form – *PRE-TREATMENT ASSESSMENT*

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.



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 use hands, affect on ADLs, etc) prior to using Anodyne.

_____

_____

_____

_____

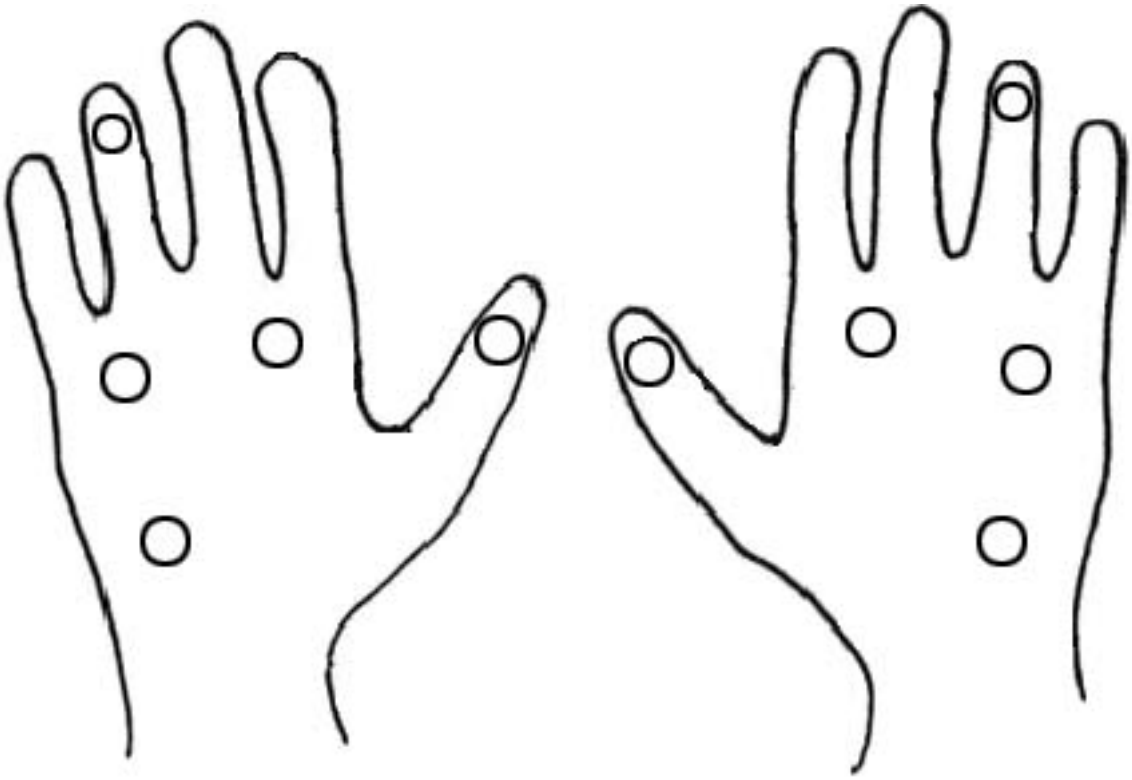
Signature _____Date_____

Hand Evaluation Form – *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.



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 use hands, do ADLs, etc.)

_____

_____

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_____

Signature _____**Date**_____