30 Day Progress Questionnaire

Patient: _____ Gender: _____ Age: _____ Date: _____

1. How much has the NERVE PAIN in your feet decreased? _____ % or N/A
2. How much has the SENSATION in your feet improved? _____ % or N/A
3. How much has your SLEEP quality improved? _____ % or N/A
4. How much has the SWELLING in your feet/legs improved? _____ % or N/A
5. How much has your BALANCE improved? _____ % or N/A
6. Are you walking better? Yes No

   If yes, explain: _____

7. Are you taking less pain or nerve medication? Yes No

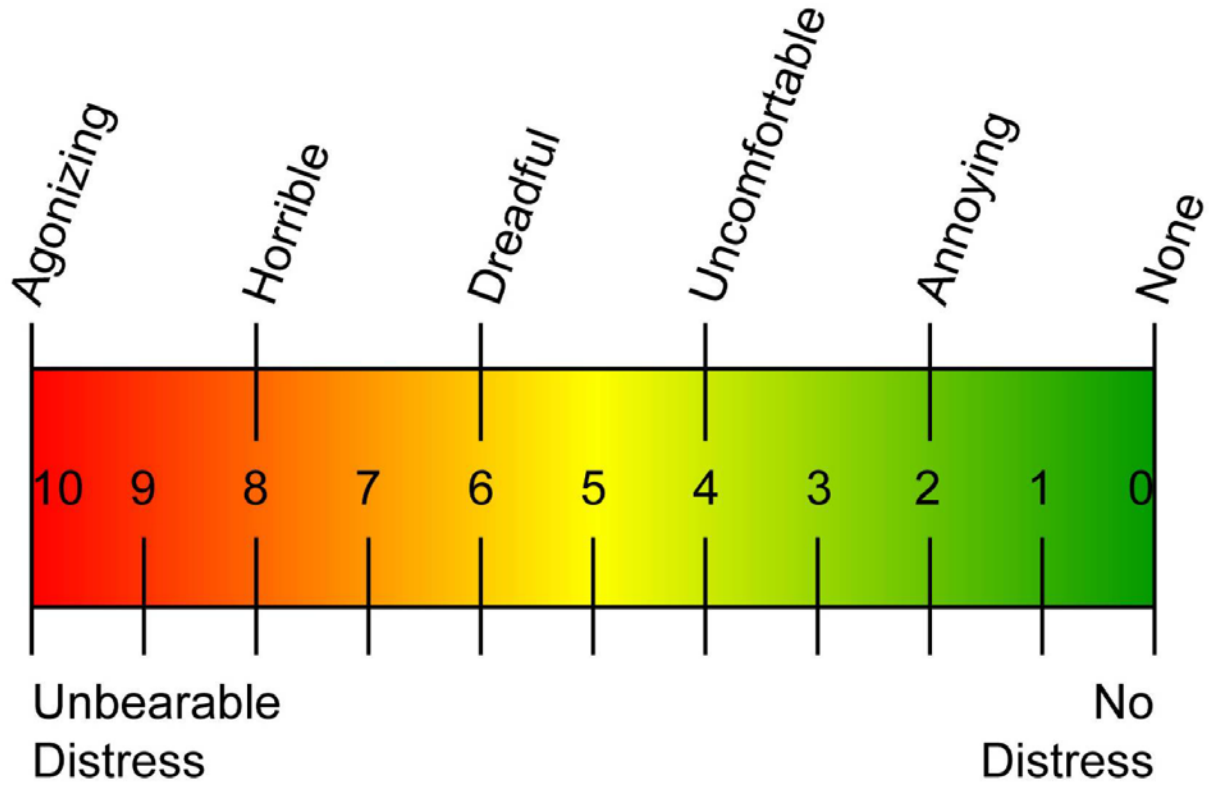
   If yes, explain: _____

8. Tell us about any other changes you have noticed that related directly to your treatment.

   _____

Below is a Pain Scale. Think carefully about how much **NERVE** pain you have in your feet. We realize every day is different and certain parts of the day may be more painful than others.

Circle **TWO** numbers below that best represents how much **NERVE** pain you have in your feet on a typical, average day. One for **WORST** and one for **BEST**.



How many hours of your day are your NERVE symptoms at their WORST? _____

How many hours of your day are your NERVE symptoms at their BEST? _____