Acumed

Dolphin Neurostim

MPS PAIN Data Collection

*DATE: _____

*Patient's FIRST NAME _____ E-mail _____

*AGE of patient: _____ SEX: M F

*LOCATION OF PAIN: _____

*DIAGNOSIS/CONDITION: _____

*DURATION OF PAIN: (ie., 5yrs) _____

IP – Pre-PAIN LEVEL - BEFORE THERAPY (0-10): **0-1-2-3-4-5-6-7-8-9 -10**

PP – Post-PAIN LEVEL - AFTER THERAPY (0-10): **0-1-2-3-4-5-6-7-8-9 -10**

***FOLLOW-UP* pain LEVEL post Treatment (0-10):** **0-1-2-3-4-5-6-7-8-9 -10**

***Duration of time of between initial & follow-up Tx:_____ (ie. 2 days or 3wks)**

***TYPE OF MPS TREATMENT**

SP - Standard Protocol

BA – Battlefield Acupuncture

SR – Scar Release - C-Section

CSR – Cranial Suture Release

SR – Scar Release "other" location Location of Scar _____

*Consent for release of video/photos, if taken: _____

*THERAPIST NAME/DATE: _____

Fax completed forms to: 904-683-6526

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