

## Effectiveness Response Form

Understanding why and how you use your device will help Avazzia improve its products. In appreciation, avazzia will mail you a set of conductive pads at no charge upon receiving your completed responses.

Please complete the following form to describe your use of the device.

Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Type of Avazzia product \_\_\_\_\_

Doctor or healthcare practitioner who recommended the product if available:

Name: \_\_\_\_\_ phone \_\_\_\_\_

What do you use your device for?

\_\_\_\_\_

Check One	No Effect	Little Effect	Effective	Very effective
Effectiveness (general)				
Pain reduction				
Ease of movement				
Return to daily activities				
Swelling				
Tight feeling				
Burning feeling				
Numbness feeling				
Skin texture				

How has the device helped you?

\_\_\_\_\_

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Check One	No Change	A Little Better	Better	A Lot Better
Sleep improvement				

How has your sleep improved?

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Check One	No Change	Slightly Less Use	Reduced Medication Use	Significant Medication Reduction
Medication use				

Please describe change in medications use:

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Check One	Once a Week or Less	Once a Day	2 – 3 Times Daily	Hours Per Day
How often do you use your device?				

Has the device's use impacted your mental or emotional state of mind? If so, explain.

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Would you recommend the device? \_\_\_\_\_yes \_\_\_\_\_no

What do you like most about the device?

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Other comments: \_\_\_\_\_

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Would you like to be added to our mailing list? \_\_\_\_\_yes \_\_\_\_\_no

Signature \_\_\_\_\_

Date \_\_\_\_\_

Thank you for your response. Please mail completed form to the information below or fax your response to 214.575.2824