VA Patient - Pain Survey

Treatment performed with the Avazzia® Microcurrent Device

Patient Name: ______________________________ Date: __________ Time: __________

Provider Name: ______________________________ Department: ____________________

Center: ______________________________ Phone: ____________________

1. Please rate patient's reported pain level BEFORE Avazzia treatment. (Circle face or number on scale below.)

2. Please describe patient's symptoms and location of the pain BEFORE Avazzia treatment.

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3. Clinical Educator: ______________________________ Device used: ☐ RSI ☐ UL ☐ PS3

   Treatment start time: __________ Treatment end time: __________ Total minutes: __________

   Protocols/modes used: ____

4. Please rate patient's pain level AFTER Avazzia treatment. (Circle face or number on scale below.)

5. Please describe patient's symptoms and location of the pain AFTER Avazzia treatment.

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☐ I want this device. ☐ I do not want this device.

Patient Signature: ______________________________________ Date: __________

Witness Signature: ______________________________________ Date: __________

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