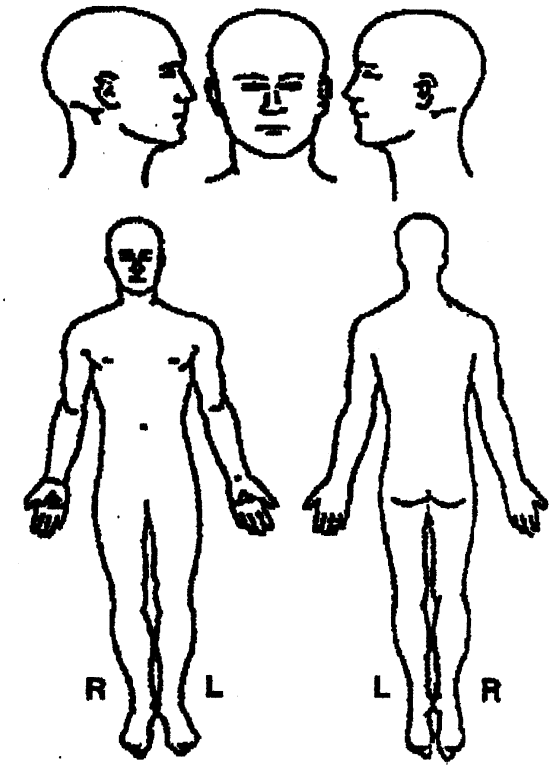
Physicians Prescription Worksheet

Pain management treatment form

Patients Name: _____ Date of birth: ___/___/____



Treatment Date	Program Number	Treatment Time	Dosage Level	Desired Electrodes

PAIN SCALE 0 = NO PAIN, 10 = SEVERE PAIN			How many hours of pain relief did the patient receive before the pain level went back to its worse number	
			Analgesic Duration Hourly Log	
Treatment Date	Before Treatment	After Treatment	Hour's	Minutes

Range of Motion Test 0 = NO PAIN, 10 = SEVERE PAIN			Pain when R.O.M. test 0 = NO PAIN, 10 = SEVERE PAIN	
Treatment Date	Before Treatment	After Treatment	Before Treatment	After Treatment

Objective:

- Stimulate peripheral nerves for the purpose of providing pain relief
- Management and symptomatic relief of chronic (long-term) ***INTRACTABLE PAIN***
- Muscle Re-education
- Increasing local blood circulation
- Maintaining or increasing range of motion
- Relaxation of muscle spasms
- Adjunctive treatment of post-traumatic pain

Date of Prescribed Treatments: _____Patients Diagnosis: (_____), (_____), (_____)

Treatment Plan: ❑ daily treatment for the first week ❑ treatments every other day

Physicians Signature: _____

❑ Scheduled re- evaluation after 5 treatments ❑ Continue Treatments ❑ Discharge patient