

Participant Number: 28 - _____

Date of Assessment: ____/____/____

Instructions: Thinking about your pain that your doctor is treating with your stimulator, please place a vertical mark (|) on each line below to indicate your average pain level over the last 48 hours.

Do not include other sources of pain that are not being treated by your stimulator, for example, a pain flare up in a different area, or unrelated pain in a new area.

1. Pain in Your Low Back (on average over the last 48 hours)



2. Pain in Your Leg(s) (on average over the last 48 hours)



3. Pain Overall (low back and/or leg pain on average over the last 48 hours)



Participant Signature

Date

Must be signed and dated by the participant to be used as a source document.