Michael Cheikin M.D., *Holistic Medicine and Physiatry*

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| MONTH OF: | | | | | | | |
| Symptom |  |  |  |  |  |  | Note  (Back) |
| Scale->  Date |  |  |  |  |  |  |  |
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| **Sample Scales:**  (A) Symptoms  0 = None  5 = Want to take medicine  10 = Go to E.R.  (B) Wellness/Energy  10 = Excellent; Can do anything  5 = Some limitations  1 = Stay in bed |  | (C) Relief: includes how well you are functioning, how much pain, duration of pain  0% = Original amount of symptom  100% = Completely gone  (D) Sleep  10 = full night, refreshed  1 = multiple interruptions, not refreshed |  |  |