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 |  |  |