

Please indicate the diagnosed condition for which you are seeking pain relief (e.g. arthritis type): _____

Date Diagnosed: _____

Length of Illness: _____

Medications: _____

Other Treatments: _____

Surgery (indicate date): _____

Metal in body (type & location): _____

Please indicate the affected area(s) of the body and the initial level of pain in each area.
Rate the level of pain on a scale of (0 – 10); where (0) is no pain and (10) is unbearable:

Affected Area: _____ Pain Level: _____

Affected Area: _____ Pain Level: _____

Affected Area: _____ Pain Level: _____

Affected Area: _____ Pain Level: _____

When recording comments and sensations we recommend that you consider including the following occurrences:

- The MyPhield does not induce vibration and does not generate heat, visible light or any other noticeable trait, but many users notice sensations of “tingling” or “light throbbing” in the area being treated. Please note these occurrences.
- Changes to pressure points or particularly sensitive areas.
- Feelings of relaxation or warmth.
- Any other sensations.



Treatment Results Tracking Sheet

Date:	Affected Area:					
Treatment Selected:	Pain (0 - 10 Scale)		Stiffness (0 - 10 Scale)		Range of Motion (+ or -)	
	Before	After	Before	After	Before	After
Comments or Sensations:						

Date:	Affected Area:					
Treatment Selected:	Pain (0 - 10 Scale)		Stiffness (0 - 10 Scale)		Range of Motion (+ or -)	
	Before	After	Before	After	Before	After
Comments or Sensations:						

Date:	Affected Area:					
Treatment Selected:	Pain (0 - 10 Scale)		Stiffness (0 - 10 Scale)		Range of Motion (+ or -)	
	Before	After	Before	After	Before	After
Comments or Sensations:						

Date:	Affected Area:					
Treatment Selected:	Pain (0 - 10 Scale)		Stiffness (0 - 10 Scale)		Range of Motion (+ or -)	
	Before	After	Before	After	Before	After
Comments or Sensations:						