THE BELEVEDRE CLINIC
Intramuscular Stimulation (IMS) Questionnaire

Today's Date: ☐☐ / ☐☐ / 20☐☐

Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ Sex: ☐ female ☐ male

This questionnaire will allow your practitioner to better understand your response to IMS therapy. In addition, your participation will assist the Belevedre Clinic in determining the efficacy of this treatment in restoring normal nerve and muscle function.

Please answer each question with the single response that reflects the most appropriate answer.

Who was your main treating practitioner? ☐ Paul ☐ John ☐ Tom ☐ Karen ☐ Terry ☐ Sharon

How many IMS treatments have you received? ☐ 1 - 5 ☐ 6 - 10 ☐ more than 10

Has IMS treatments changed your symptoms?
☐ decreased significantly ☐ decreased slightly ☐ no change ☐ increased slightly ☐ increased significantly

Did you have any negative complications as a result of the treatments you received that caused you to seek medical care? ☐ no ☐ yes if yes, explain:

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Have you experienced any long-term negative effects from the IMS treatment? ☐ no ☐ yes if yes, explain:

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How would you rate IMS versus other treatments you have tried?
☐ better than all ☐ better than most ☐ same as others ☐ worse than most ☐ worse than all

Would you recommend IMS to a family member or friend with pain? ☐ no ☐ yes

Have you altered your intake of pain medication since starting the IMS treatments?
☐ not applicable: no medication taken for this condition ☐ medications have been slightly reduced
☐ no medication required now ☐ no change in medications
☐ medication has been significantly reduced ☐ medications have increased

Have your daily activities been altered since receiving IMS treatment?
☐ significant increase ☐ slight increase ☐ no change ☐ slight decrease ☐ significant decrease