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Patient Instruction
HUS Diagnostic Center
Clinical Neurophysiology
www.tutkimukseen.fi

Pain and sleep quality follow-up BEFORE intensive rTMS therapy FORM 1

Two weeks follow-up before rTMS therapy

Name: ________________________________ **ID:** ______________________

Year ____________	PAIN FOLLOW-UP Evaluate the pain strength at the asked moment of time in 0-10 score (0 = no pain, 10 = the worst possible pain)		SLEEP QUALITY FOLLOW-UP How much does the pain disturb sleep? (0 = not at all, 10 = the worst possible disturbance)	THERAPY EXPECTATIONS Choose the suitable answer from following statements. I expect, that rTMS: – does not affect the pain at all, reduces the pain – less than half, – about half, – more than half or – completely.
dd.mm	Morning 8-10 o'clock	Evening 19–21 o'clock	Morning 8-10 o'clock	

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