



Effectiveness Response Form

Understanding why and how you use your device will help us as we seek to improve our products. To show our appreciation, we will mail you 1 set of conductive pads at no charge upon receiving your completed responses.

Please complete the following form to describe your use of the device.

Name _____ Date _____

Address _____

Phone _____

Email _____

Type of Avazzia product _____

Doctor or healthcare practitioner who recommended the product if available:

Name: _____ phone _____

What do you use your device for?

Check one:	No effect	Little effect	Effective	Very effective
Effectiveness - general				
Pain reduction				
Ease of movement				
Return to daily activities				
Swelling				
Tight feeling				
Burning feeling				
Numbness feeling				
Skin texture				

How has the device helped you if any?

Check one:	No change	A little better	Better	A Lot better
Sleep improvement				

How has your sleep improved if any?



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Check one:	No change	Slightly less use	Reduced use of medication	Significant reduction in medication
Medication use				

Please describe change in medication use if any:

Check one:	Once a week or less	Once a day	2 to 3 times daily	Hours per day
How often do you use your device?				

What physiological effects has the device had for you?

Would you recommend the device? yes no

What do you like most about the device?

Please provide other comments

Would you like to be added to our mailing list? yes no

Signature

Date

Thank you for your response.
Please **mail** completed form to:

Or **fax** to: **214-575-2824**

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