

# ReBuilder Evaluation Study Enrollment Form

Name : \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Please enroll me in your ReBuilder Evaluation study. I will use the ReBuilder as instructed for 10 days, fill out and return the three forms in the envelope provided within 5 days of my last treatment.

I have been informed that my results will be tabulated, evaluated, and reported relative to the results only, and that no personal information will be revealed or available to anyone other than the directors of this study. I understand that this evaluation study is informal and is to be used to help determine if this modality shows promise to help manage the peripheral neuropathy, regardless of the cause(s). I have not been promised any particular clinical outcome.

I have been informed that the ReBuilder is non-invasive. I do not have any implanted electrical devices such as a pacemaker or insulin pump.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## ReBuilder™ Evaluation Kit

Thank you for agreeing to participate in our evaluation of the ReBuilder. When you have finished this evaluation, please return it to us as soon as possible in the postage pre-paid envelope provided.

This package includes your agreement to participate and 3 forms to record your experience with the ReBuilder for ten days and the envelope with which to return the 3 forms to us.

Form number one will note your relative levels of pain (if pain is one of your symptoms) on a scale of 1 to 10 with ten being the highest level of discomfort, just before you use the ReBuilder, and right after you use the ReBuilder. (If pain is not one of your symptoms please mark N/A on the form.)

Form number two will note your relative levels of numbness and/or tingling (if numbness is one of your symptoms) on a scale of 1 to 10 with ten being the highest level of numbness and/or tingling, just before you use the ReBuilder, and right after you use the ReBuilder. (If pain is not one of your symptoms please mark N/A on the form.)

If using the ReBuilder **once per day** for 30 minutes, you will only use the first ten spaces only.

If you choose to use the ReBuilder **twice a day** rather than once, then you will fill up all 20 spaces on the forms.

Form three is a questionnaire that notes any overall improvement in your quality of life, if you feel that your symptoms have improved, if you plan to continue using the ReBuilder after this initial evaluation, and if you would recommend the ReBuilder to others who have symptoms similar to yours and feel free to add other interesting observations.

## Form #1: Pain levels

Treatment #	Date	Pain level before treatment.	Pain level right after treatment
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

## Form #2: Numbness and tingling levels

Treatment #	Date	Numbness and tingling level before treatment.	Numbness and tingling level right after treatment
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

### Form #3: Overall quality of life evaluation and comments

- 1. Do you feel that your symptoms improved with the ReBuilder? Yes\_\_\_\_ No\_\_\_\_
- 2. Do you feel that the ReBuilder was easy to use? Yes\_\_\_\_ No\_\_\_\_
- 3. Would you recommend the ReBuilder to others? Yes\_\_\_\_ No\_\_\_\_
- 4. Would you voluntarily continue to use the ReBuilder? Yes\_\_\_\_ No\_\_\_\_
- 5. Do you feel that your quality of life was improved? Yes\_\_\_\_ No\_\_\_\_
- 6. Had you tried prescription pain meds before using the ReBuilder? Yes\_\_\_\_ No\_\_\_\_
- 7. Which treatment was better- the pain meds or the ReBuilder?  
ReBuilder\_\_\_\_Meds\_\_\_\_
- 8. Were you taking pain meds with the ReBuilder? Yes\_\_\_\_ No\_\_\_\_
- 9. If so, which prescription medicines and how many milligrams per day? \_\_\_\_\_

Please provide any comments you would like to record relative to your particular symptoms, situation, medical history, etc., please do so below:

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\_\_\_\_\_  
Name

\_\_\_\_\_  
Date