

PLEASE USE BLOCK CAPITALS

TRIAL FORMS PROCESSING

Mr Mrs Miss Other

First Name:

Last Name:

Phone No: ()

Patient ID:

Date of Birth: / /


House:

Street:

Town:

Postcode: -

Address validated with eSearch



Please mark each scale clearly with a vertical line to indicate your response to each question

How would you rate your alertness?

How would you rate your ability to awake in the mornings?

How would you rate the overall progress during this trial?

P O R | _____ | P O R

P O R | _____ | P O R

P O R | _____ | P O R

Trial specifics - Motor function - indicate any issues with a X in the boxes

LEFT		RIGHT	LEFT		RIGHT
<input type="checkbox"/>	Hip flexion	<input type="checkbox"/>	<input type="checkbox"/>	Toe flexion	<input type="checkbox"/>
<input type="checkbox"/>	Hip extension	<input type="checkbox"/>	<input type="checkbox"/>	Toe extension	<input type="checkbox"/>
<input type="checkbox"/>	Knee extension	<input type="checkbox"/>	<input type="checkbox"/>	Ankle plantar flexion	<input type="checkbox"/>
<input type="checkbox"/>	Ankle dorsiflexion	<input type="checkbox"/>	<input type="checkbox"/>	Ankle eversion	<input type="checkbox"/>

Have you noticed any points of pain that have started during the course of this trial? Yes No

If **yes**, please indicate with one or more **X** on diagram:

Please use this space to indicate any other observations:

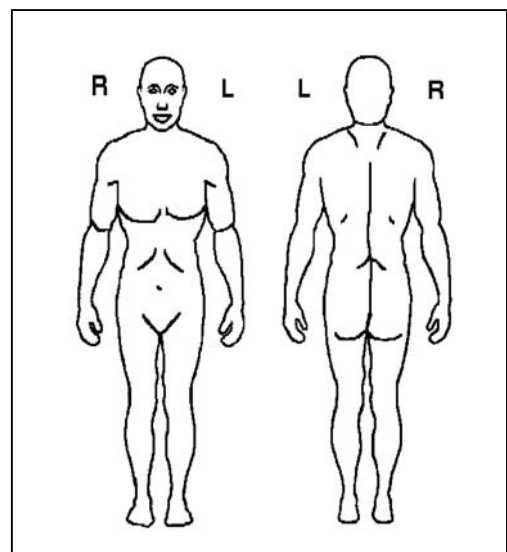


Image and positional data extracted

