MedX Phototherapy Evaluation

Patient Journal

Clinician Name: _____ Patient Name: _____

Site: _____ Diagnosis: _____

Evaluation Date: _____

- Determine goal of treatment or outcome to be measured.
  (Example: pain, range of motion, swelling, wound size) Rate pain with 1 – 10 scale.
  Rate outcome **before** and **after** phototherapy.

PT PAIN SCALE 0-1-2-3-4-5-6-7-8-9-10 0=No Pain; 10=Severe Pain

TX 1 Date: _____ Joules: _____

PT/Clinician Comments:

TX 2 Date: _____ Joules: _____

PT/Clinician Comments:

TX 3 Date: _____ Joules: _____

PT/Clinician Comments:

TX 4 Date: _____ Joules: _____

PT/Clinician Comments:

TX 5 Date: _____ Joules: _____

PT/Clinician Comments:

TX 6 Date: _____ Joules: _____

PT/Clinician Comments: