



**Numbness/Paralysis**

Date	0	1	2	3	4	5	6	7	8	9	10	Comments

*Note: Choose the area with the worst numbness or the area you worked on today. List all areas that are numb.  
**Scale** (example: 0=none, 9="tingly numbness", 10="paralysis (if numbness is in deep tissue)":*

**Muscle Weakness**

Date	0	1	2	3	4	5	6	7	8	9	10	Comments

***Scale** (example: 0="I feel strong", 7="muscle tremors w/moderate effort (e.g. climbing stairs), 10="I can't move it"):*

**Headache**

Date	0	1	2	3	4	5	6	7	8	9	10	Comments

***Scale** (example: 0=no pain, 3="can't ignore it", 7 or 8="wants medication", 10="excruciating"):*

**Mental Capacity Impairments**

Date	0	1	2	3	4	5	6	7	8	9	10	Comments

*Scale (0="feeling sharp, good memory", 10="huh?"):*

**Vision Impairment**

Date	0	1	2	3	4	5	6	7	8	9	10	Comments

*Scale:*

**Speech Impairment**

Date	0	1	2	3	4	5	6	7	8	9	10	Comments

*Scale:*

