Global Rating of Change Scale

Date: _____ dd / mm / yyyy

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Chief complaint:

PATIENT GLOBAL IMPRESSION OF CHANGE SCALE

Since beginning treatment at this clinic, how would you describe the change, if any, in your ACTIVITY LIMITATIONS, SYMPTOMS, EMOTIONS, AND OVERALL QUALITY OF LIFE related to your painful condition?

- ◯ No change (condition has not improved or worsened (1)
- ◯ Almost the same, hardly any change at all (2)
- ◯ A little better, but no noticeable change (3)
- ◯ Somewhat better, but the change has not made a real difference (4)
- ◯ Moderately better, and a slight but noticeable change (5)
- ◯ Better, with a definite improvement that has made a worthwhile difference (6)
- ◯ A great deal better, with a considerable improvement that has made all the difference (7)

ADDITIONAL NOTES

Specify below: