1. What level of pain relief did you experience DURING your treatment with SPRINT (before your lead was withdrawn)?

¨ 0% (No Relief)

¨ 10%

¨ 20%

¨ 30%

¨ 40%

¨ 50%

¨ 60%

¨ 70%

¨ 80%

¨ 90%

¨ 100% (Complete Relief)

1. For how many months after the end of the SPRINT treatment did you obtain at least 50% pain relief?
2. For how many months after the end of the SPRINT treatment did you obtain at least 30% pain relief?
3. How would you rate your amount of pain relief NOW compared to the pain you experienced prior to your treatment with SPRINT?

¨ 0% (No Relief)

¨ 10%

¨ 20%

¨ 30%

¨ 40%

¨ 50%

¨ 60%

¨ 70%

¨ 80%

¨ 90%

¨ 100% (Complete Relief)

1. Please select the one number below that best describes your pain at its AVERAGE in the last WEEK on a scale from 0-10 where 0 = no pain, 10 = worst pain imaginable?

¨ 0 (No Pain)

¨ 1

¨ 2

¨ 3

¨ 4

¨ 5

¨ 6

¨ 7

¨ 8

¨ 9

¨ 10 (Worst Pain Imaginable)

1. Does your pain currently impact your sleep?

¨ Yes

¨ No

1. Please select the best answer for each type of prescription drug in the table below that you may have used for your pain that was treated with SPRINT PNS.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | I have NEVER used this type of drug for my pain | I have STOPPED using this type of drug since my SPRINT treatment | I am using LESS of this type of drug now than before my SPRINT treatment | My use of this type of drug has NOT CHANGED since before my SPRINT treatment | I am using MORE of this drug now than before my SPRINT treatment | I don’t know |
| Opioids (oxycontin, Percocet, etc.) | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ |
| Neurontin (gabapentin) or Lyrica (pregabalin) | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ |
| Anti-depressants | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ |

1. What treatments, if any, did you use for your pain before and after receiving SPRINT PNS? Select all that apply. If none apply, please click on “None of the below”.

|  |  |  |
| --- | --- | --- |
|  | Before SPRINT | After SPRINT |
| None of the below | ¨ | ¨ |
| Over-the-counter pain relievers (Tylenol, Motrin, Aleve, etc.) | ¨ | ¨ |
| Physical therapy | ¨ | ¨ |
| Injections | ¨ | ¨ |
| TENS | ¨ | ¨ |
| Surgery | ¨ | ¨ |

1. Comparing how you feel now to how you felt before starting SPRINT treatment, how would you rate the change (if any) in your quality of life?

¨ Very Much Worse

¨ Much Worse

¨ Minimally Worse

¨ No Change

¨ Minimally Improved

¨ Much Improved

¨ Very Much Improved

1. Comparing how you feel now to how you felt before starting SPRINT treatment, how would you rate the change (if any) in your physical function?

¨ Very Much Worse

¨ Much Worse

¨ Minimally Worse

¨ No Change

¨ Minimally Improved

¨ Much Improved

¨ Very Much Improved

1. Please select the number below that describes how, in the last WEEK, your pain has interfered with each of the following, on a scale from 0 (does not interfere) to 10 (completely interferes).

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 = does not interfere | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 = completely interferes |
| General Activity | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ |
| Mood | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ |
| Walking Ability | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ |
| Normal Work (includes both work outside the home and housework | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ |
| Relations with other people | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ |
| Sleep | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ |
| Enjoyment of life | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ | ¨ |