Patient Name: _____ Date: _____

Global Rating of Change Scale:

Please rate the overall condition of your injured body part or region FROM THE TIME THAT YOU BEGAN TREATMENT UNTIL NOW (Check only one):

_____A very great deal worse (-7)
_____A great deal worse (-6)
_____Quite a bit worse (-5)
_____Moderately worse (-4)
_____Somewhat worse (-3)
_____A little bit worse (-2)
_____A tiny bit worse (-1)

_____A very great deal better (7)
_____A great deal better (6)
_____Quite a bit better (5)
_____Moderately better (4)
_____Somewhat better (3)
_____A little bit better (2)
_____A tiny bit better (1)
_____About the same (0)