Name:
MRN:
Date:
Study Number:

POST-BIOPSY: Parent

Laser acupuncture study

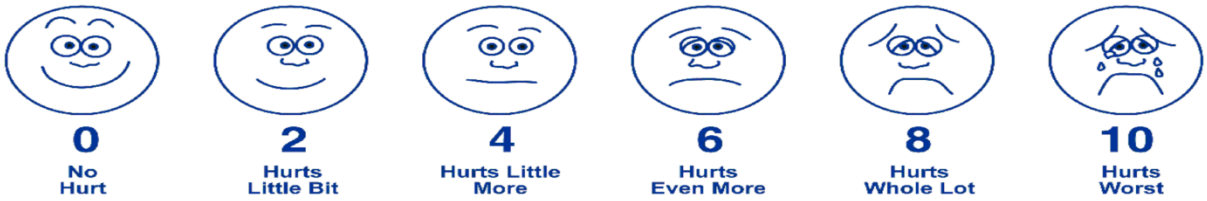
1. How anxious do you feel right **now**? Please circle a number:

0	1	2	3	4	5	6	7	8	9	10
Not at all		Little			Medium			A lot		Worst imaginable

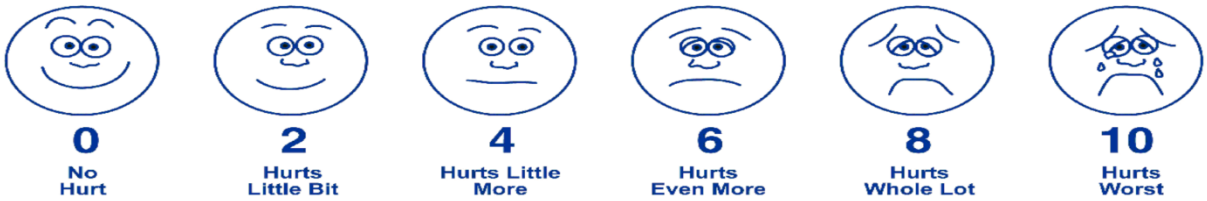
2. How anxious does your child feel right **now**? Please circle a number:

0	1	2	3	4	5	6	7	8	9	10
Not at all		Little			Medium			A lot		Worst imaginable

3. Is your child in pain right **now**? Please circle a number:



4. If you were present, do you think your child had pain **during** the biopsy. Please circle a number, if yes:



5. If your child has had a biopsy in the past, was this experience
   a. Better
   b. The same
   c. Worse

6. If your child has had a biopsy in the past, was the pain he/she felt TODAY
   a. Better
   b. The same
   c. Worse

7. Do you think your child received real laser acupuncture today? Circle one.
   Yes No

8. Would you want your child to have laser acupuncture in the future? Circle one.
   Yes No

9. Would you recommend laser acupuncture to someone else having a kidney biopsy? Circle one.
   Yes No

10. Do you think laser acupuncture could be helpful for other types of procedures? Circle one.
    Yes No

    If so, what type of procedure? _____

11. What could we do to make this experience better?