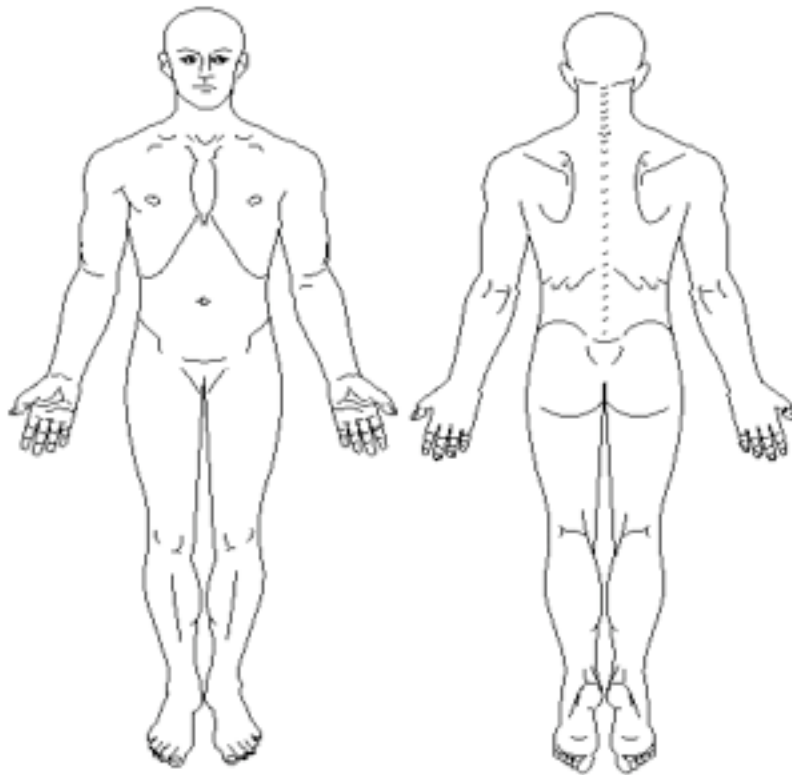


**Pain & Symptoms**

On the diagram below, please indicate the area or areas where you are currently experiencing pain or other symptoms by marking those areas with an X on the diagram.



**How would you describe your symptoms? (Mark all that apply)**

Dull, aching     Sharp, stabbing     Burning    Other: \_\_\_\_\_

**Are you having any numbness or tingling?**

If so, describe what areas and how long it lasts: \_\_\_\_\_

**Rate your pain level using the scales below (0=no pain, 10=severe pain)**

Current pain level:            0    1    2    3    4    5    6    7    8    9    10

Pain level at best:            0    1    2    3    4    5    6    7    8    9    10

Pain level at worst:           0    1    2    3    4    5    6    7    8    9    10

**Are you having any other symptoms that you need to bring to our attention?**

If so, please describe these symptoms: \_\_\_\_\_