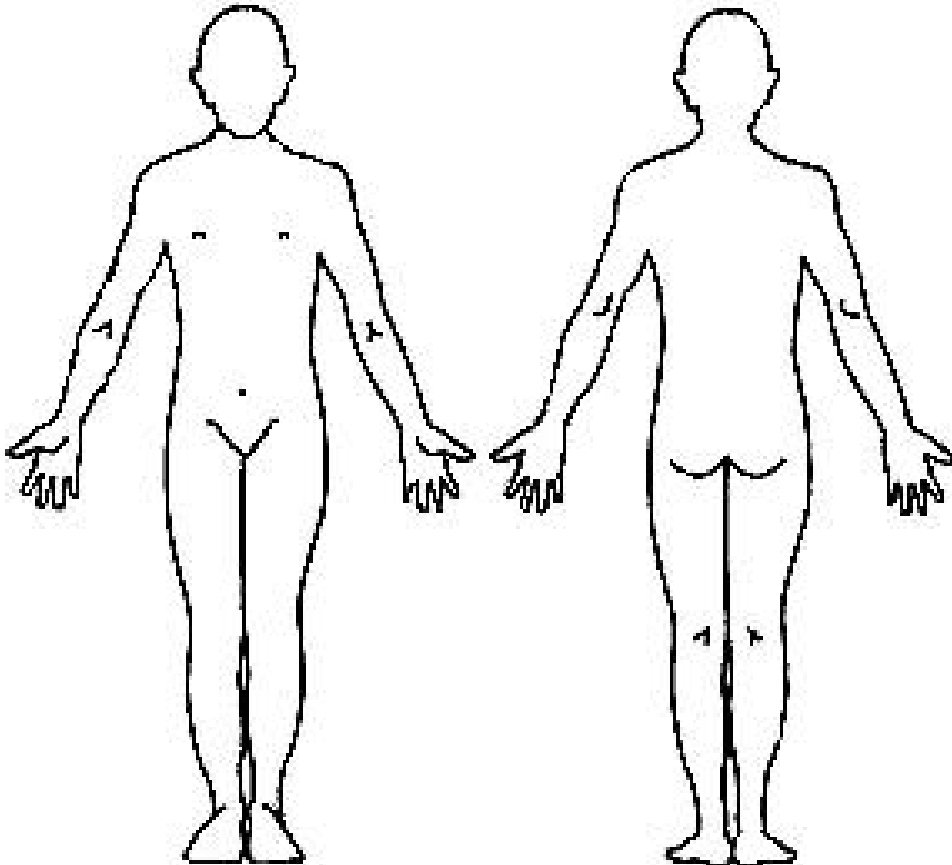


Describe the Areas of Pain Involved

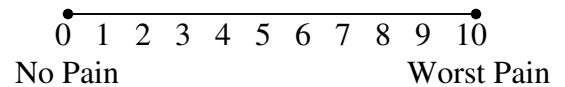
Indicate the location and type of sensation that you are experiencing on the body below.

- //////// Sharp/Stabbing pain
- **** Aching
- XXX Burning
- 00000 Numbness

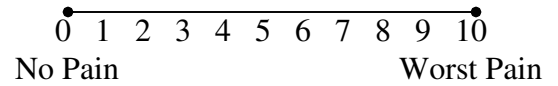
On the scales below indicate the severity of your pain from zero to 10.



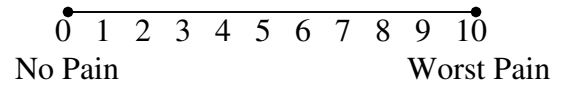
Neck-Shoulder-Arm Pain



Mid Back Pain



Low Back and Leg Pain



Do you experience any of the following as a result of your pain?

- | | |
|---|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Difficulty breathing or taking full breaths |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Mood changes |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Changes in appetite |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stomach or intestinal irritation or problems |
| <input type="checkbox"/> Difficulty concentrating | |

Date

Signature