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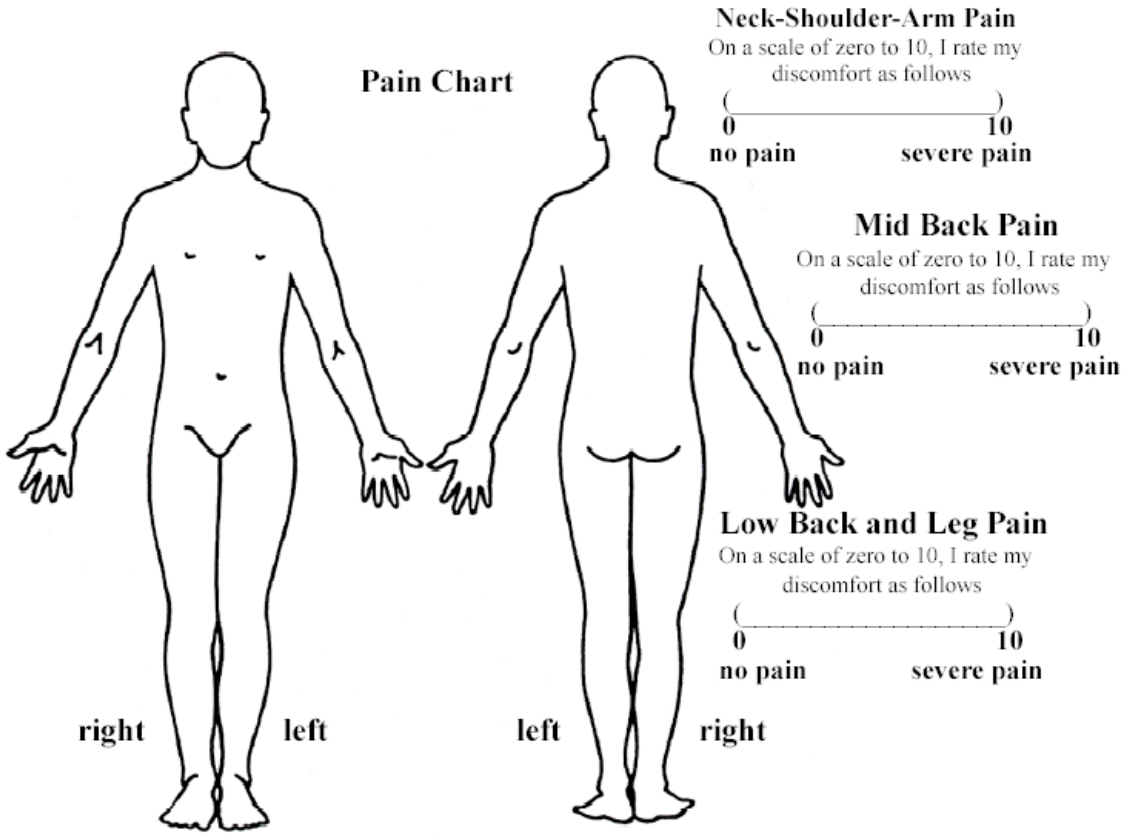
SHOW AREA(S) OF PAIN OR OTHER SYMPTOMS.

Mark the areas on this body where you feel the described sensations. Make up your own if these do not accurately describe them. Mark areas of radiating/shooting pain. Include all affected areas. Include headaches and any other symptoms that you might have. (i.e. Muscle spasms, stiffness, weakness)

0= No symptoms. 10= worst symptoms you can imagine. Put a mark on the line somewhere between zero and ten.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	OOOOO	xxxxx	*****	/ / / / /
- - - - -	OOOOO	xxxxx	*****	/ / / / /
- - - - -	OOOOO	xxxxx	*****	/ / / / /



Are you taking medications (prescription or non-prescription) in order to minimize your symptoms? No. Yes.

If yes, what are you taking and how much?_____.

Your MAIN symptoms are (circle one): Infrequent Occasional Frequent Constant

Print Patient Name:_____ Signature:_____
Date: __/__/___