

Name _____ Number _____ Date _____

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

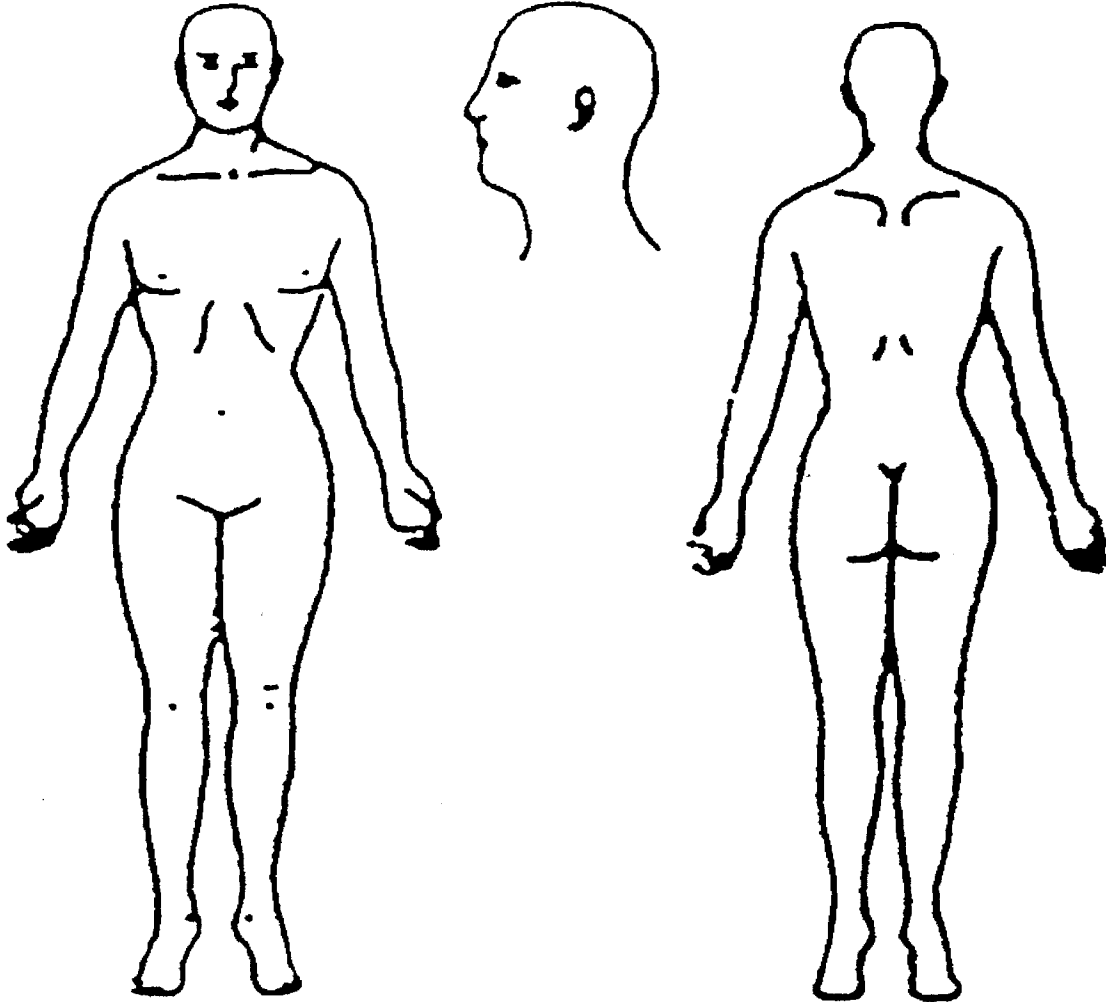
Aches $\wedge\wedge\wedge$

Numbness oooo

Pins/Needles ●●●●

Burning xxxx

Stabbing ///



Indicate the severity of your symptoms by marking an "X" on the lines below:

How bad are your symptoms now?

None Most Severe

How bad have they been in the past?

None Most Severe