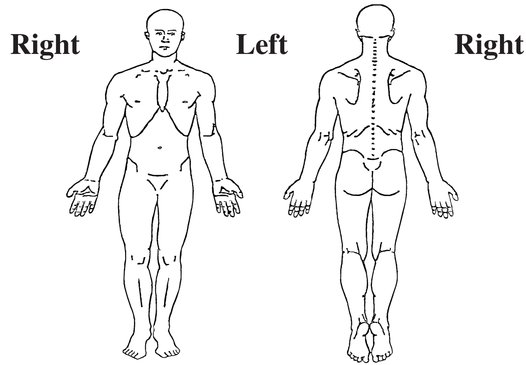
NAME: ______________________________ **DOB:** ______________ **AGE:** ___________ **DATE:** _____________

WHEN DID YOUR SYMPTOMS START? ____

PLEASE MARK ON THE DRAWING BELOW THE AREAS WHERE YOU FEEL PAIN

NUMBNESS	STABBING	PINS & NEEDLES	BURNING	ACHING
=======	/////////	○○○○○○○	XXXXX	^^^^^^



Mark on the line below to designate how intense your pain is at the PRESENT TIME

No pain ____ **Severe pain**

0 1 2 3 4 5 6 7 8 9 10

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