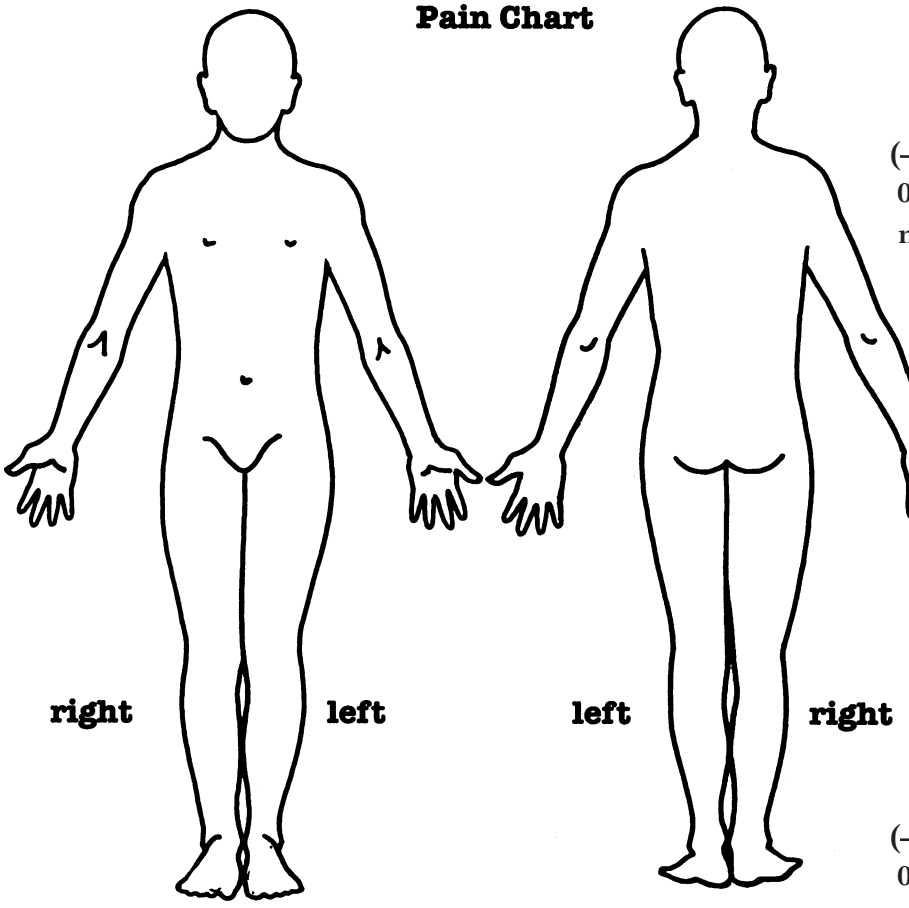
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins &- Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/ / / / /
- - - - -	00000	xxxxx	*****	/ / / / /
- - - - -	00000	xxxxx	*****	/ / / / /

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.



Neck-Shoulder-Arm Pain
On a scale of zero to 10,
I rate my discomfort as follows
(———————————————————)
0 10
no pain severe pain

Mid Back Pain
On a scale of zero to 10,
I rate my discomfort as follows
(———————————————————)
0 10
no pain severe pain

Lower Back Pain
On a scale of zero to 10,
I rate my discomfort as follows
(———————————————————)
0 10
no pain severe pain

Date _____ Signature _____