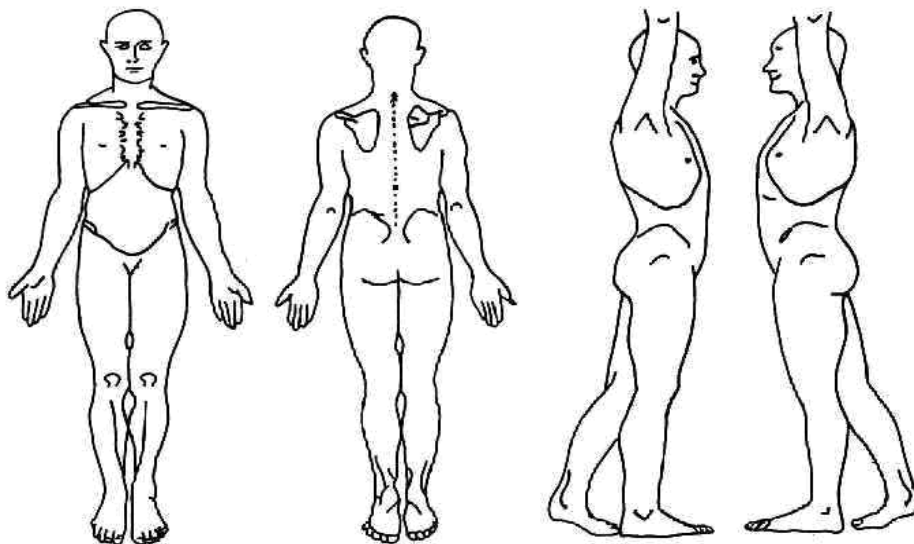


Name:

Date:

Please indicate where you are experiencing your pain/symptoms



What is the nature of your symptoms?

Numbness/Tingling

Shooting Discomfort

Burning Discomfort

Sharp Discomfort

Dull Ache

Weakness

Stiffness

Lack of Energy

What is the intensity level of your symptoms?

At Best

0	1	2	3	4	5	6	7	8	9	10
None					Moderate					Severe

At Worst

0	1	2	3	4	5	6	7	8	9	10
None					Moderate					Severe

On Average

0	1	2	3	4	5	6	7	8	9	10
None					Moderate					Severe

Pain increases during the following activities

Pain decreases during the following activities