Patient Name: _____ **Referring Doctor:** _____

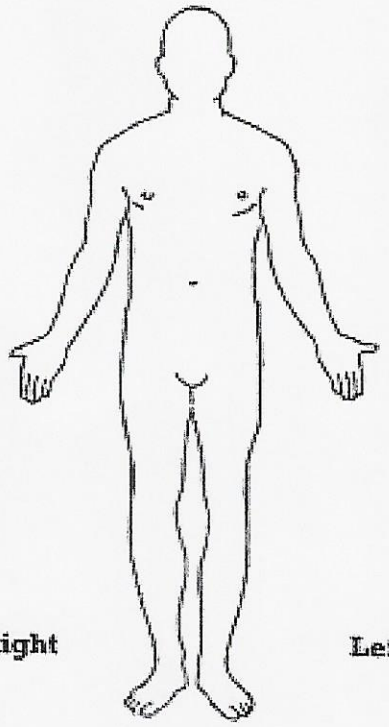
Age: _____

Patient Profile
In the past 30 days

Now: _____ **Best:** _____ **Worst:** _____

No Pain		Low			Moderate			Intense		Unbearable
0	1	2	3	4	5	6	7	8	9	10

Indicate the location and type of your pain

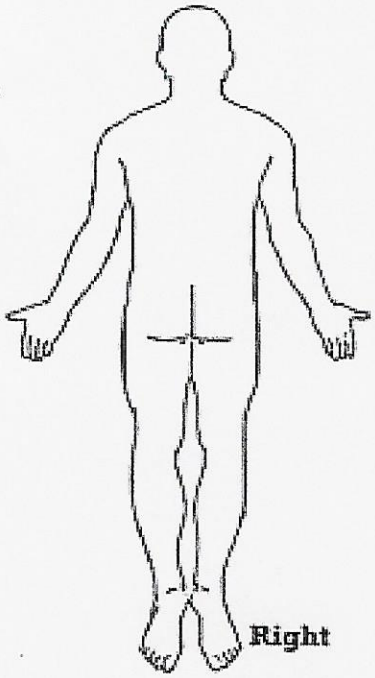


Right **Left**

Front

Keys

000000	Pins & Needles
XXXXX	Burning
////////	Stabbing
=====	Numbness
+++++	Aching



Left **Right**

Back