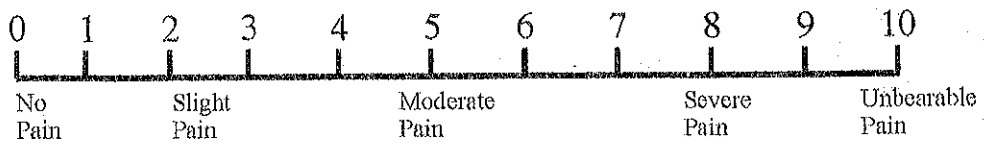
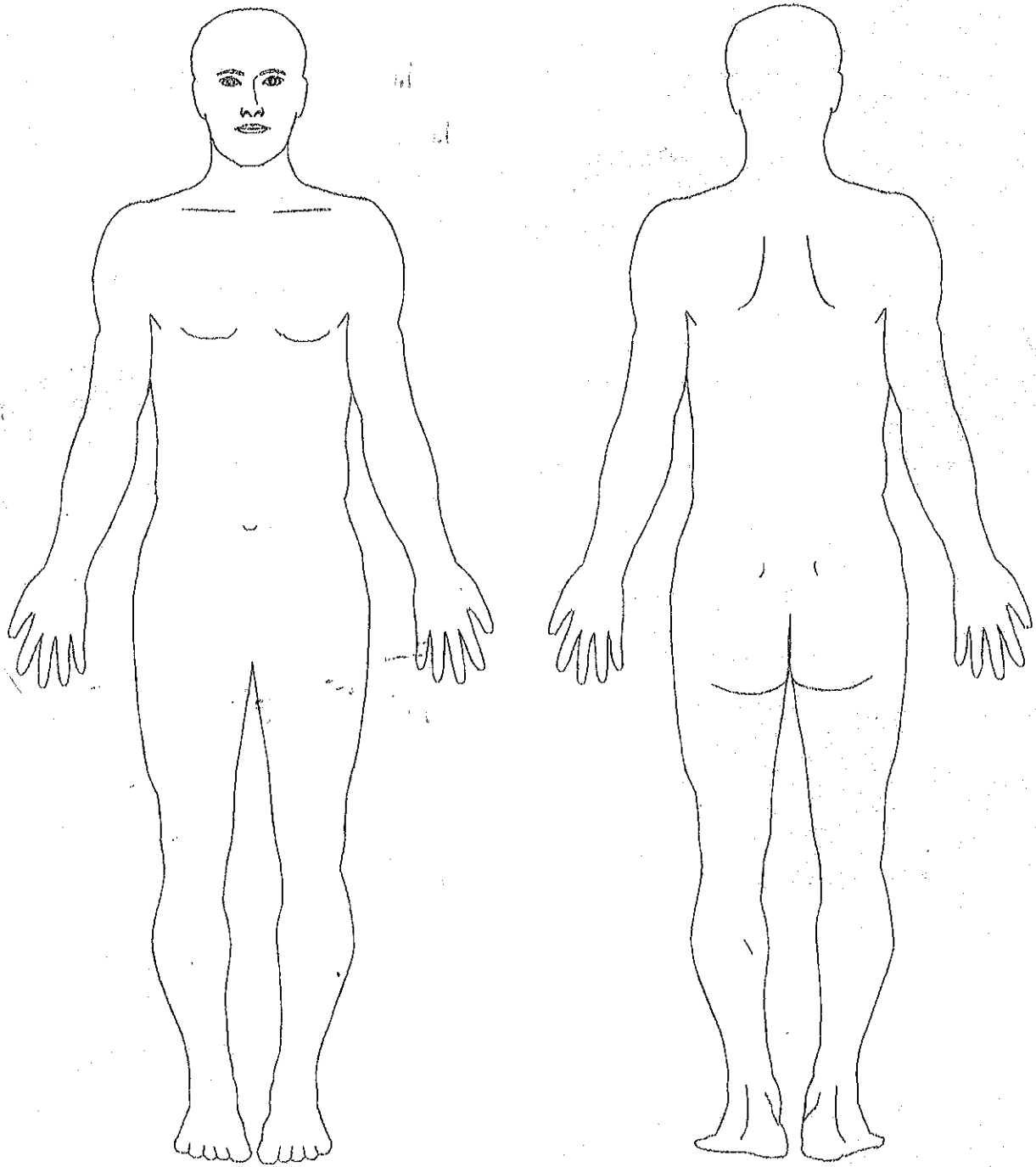


Date _____ Name _____

Mark the areas of the body where you feel pain or discomfort. Include all areas.



Patient Signature