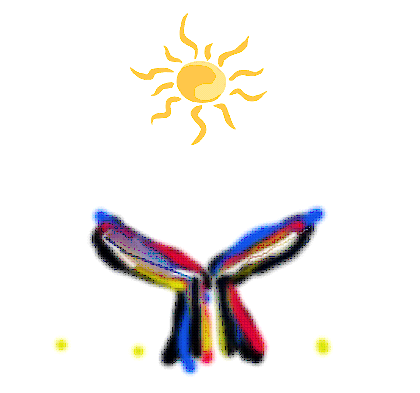
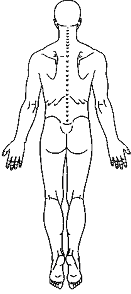
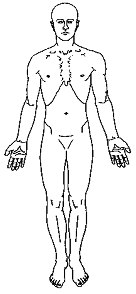
**Hands On Therapeutics**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Using the symbols, please mark on the diagram where you feel discomfort. Please be as detailed as possible. Feel free to write in any details.

****

/// Stabbing, Sharp

XXX Burning

000 Pins & Needles

=== Numbness

+++ Aching

Please circle the least and the most amount

of pain you have experienced since your last visit.

Then draw and X over the number representing

the pain you are experiencing right now.

0 1 2 3 4 5 6 7 8 9 10

No Pain Emergency Room