**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.

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/// 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