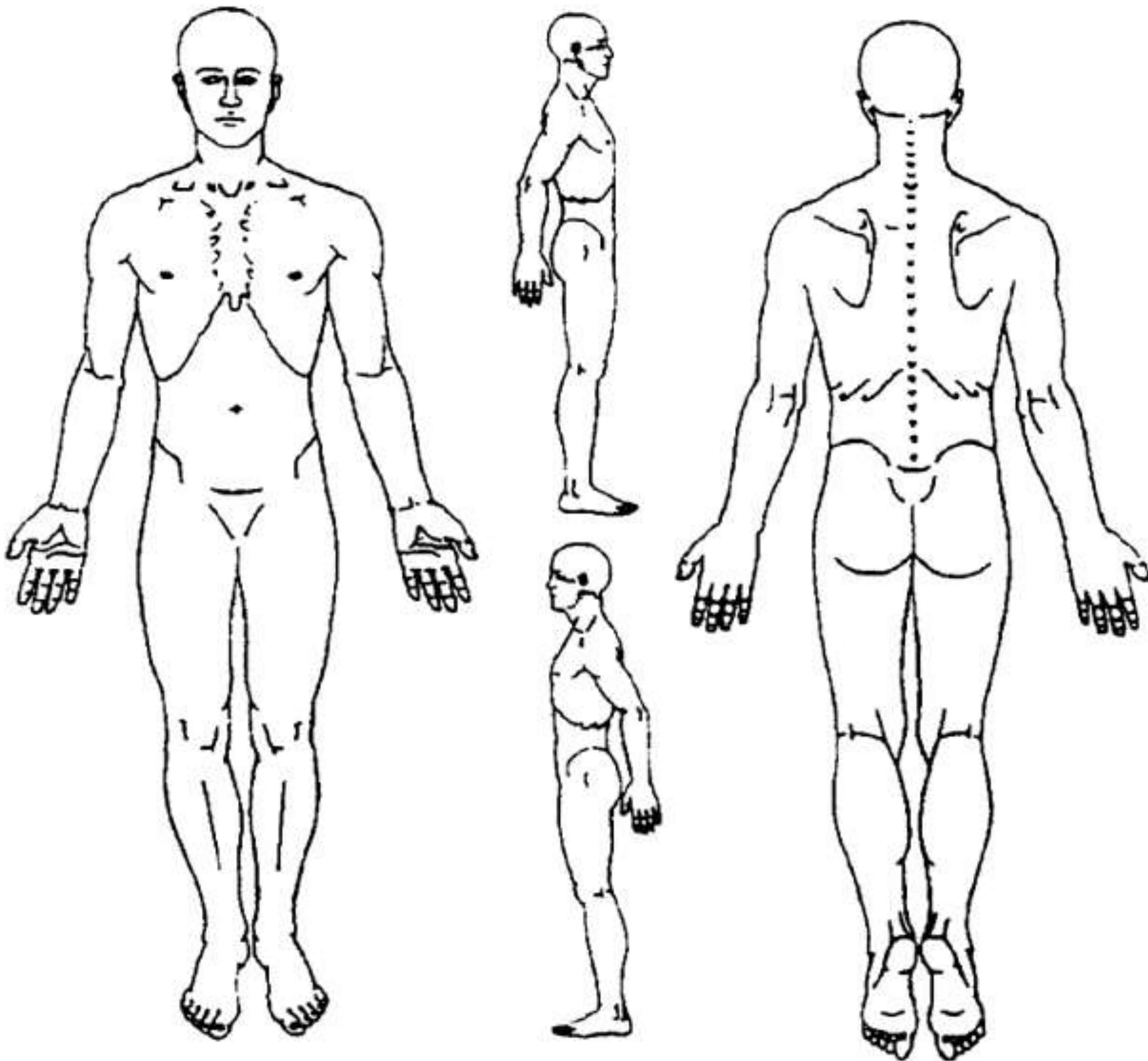
PAIN DIAGRAMS

Patient Name: ____ Date: _______________________
In the diagrams below, circle all the areas where you are currently experiencing pain and or other symptoms.

Other symptoms not included in the diagram:
Headache: __ Yes/ __ No
Other: ____



Patient Signature: ____ Date: _______________________