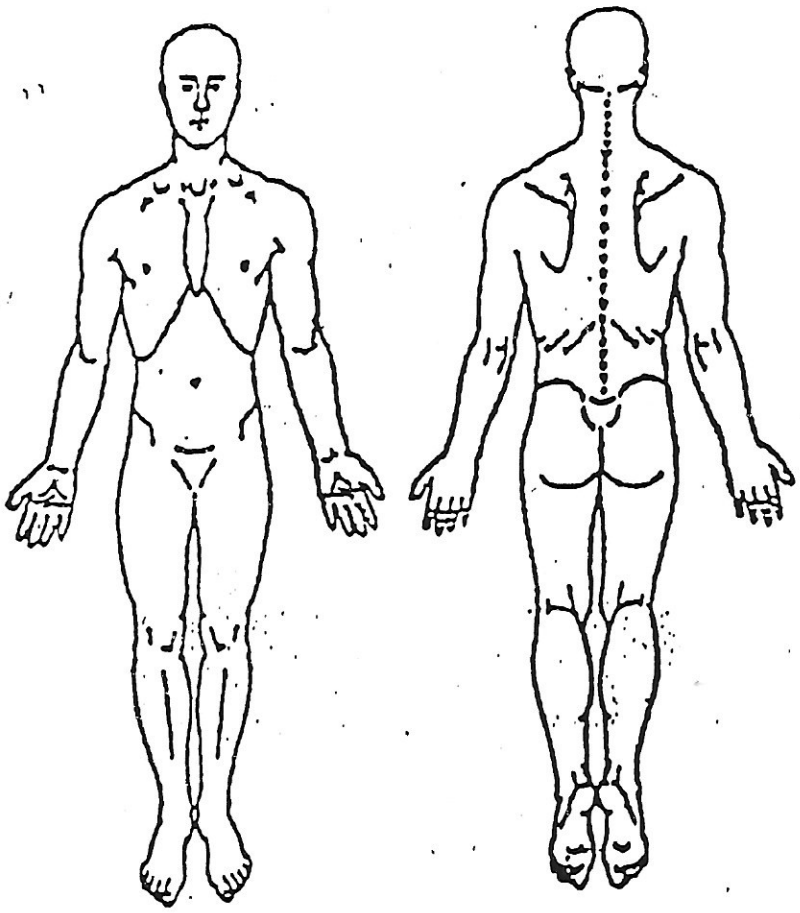
PLEASE INDICATE BELOW WHERE YOUR SYMPTOMS ARE LOCATED.



KEY:	
Numbness	═══
Pins & Needles	oooooooo
Burning Pain	xxxxxxx
Stabbing Pain	///////

IF YOU ARE HAVING PAIN, PLEASE RATE THE INTENSITY OF YOUR PAIN ON A SCALE OF 0 TO 10, WITH 0 BEING NO PAIN AND 10 BEING THE WORST PAIN POSSIBLE _____.

_____

Patient Signature

_____

Parent or Guardian

_____

Date