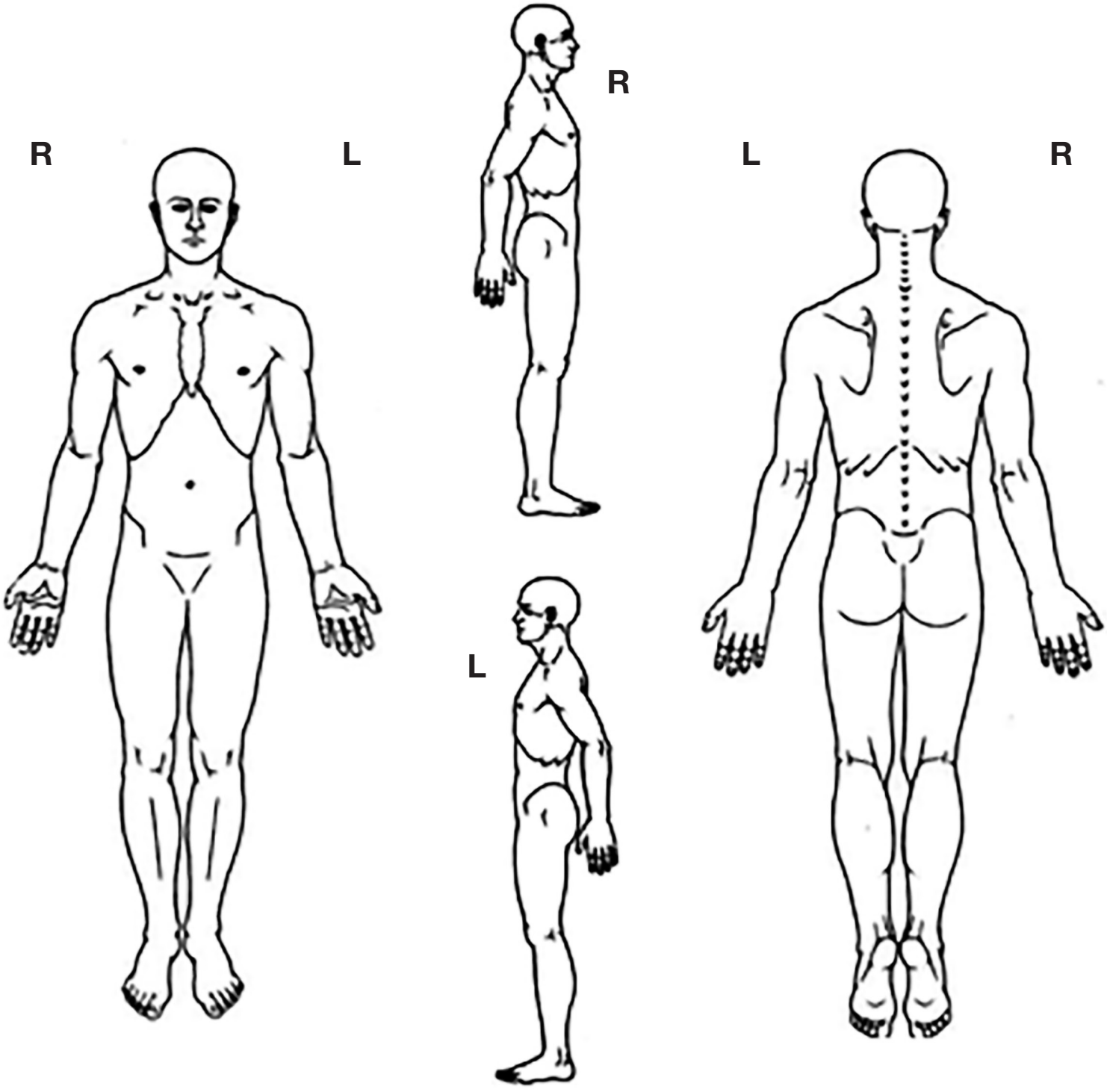
Name: _____ File #: _____ Date: _____

On a scale of 0 to 10, please circle pain level

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **WORST**



Please* CIRCLE *area(s) of complaint