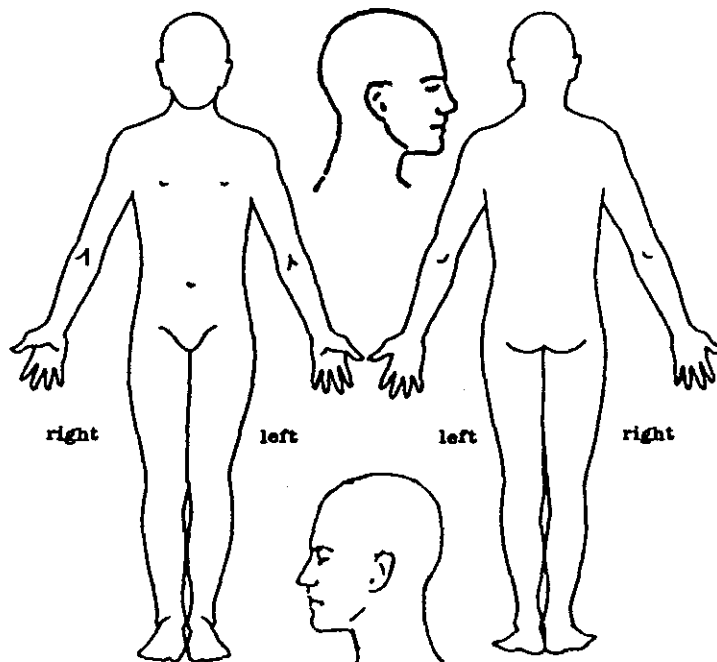


**SHOW AREA(S) OF PAIN OR UNUSUAL FEELING**

Mark the areas on this body where you feel the described sensations.  
 Use the appropriate symbols.  
 Mark areas of radiation.  
 Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	00000	XXXXXX	*****	/////
-----	00000	XXXXXX	*****	/////
-----	00000	XXXXXX	*****	/////

**Pain Chart**



**INDICATE ABILITY TO PERFORM THE FOLLOWING ACTIVITIES**

USE CODES:

**U - Unable      P - Painful      D - Difficult      L - Limited      N - Normal**

- |   |  |
|---|--|
| <input type="checkbox"/> Coughing or sneezing           | <input type="checkbox"/> Climbing        |
| <input type="checkbox"/> Getting in or out of a car     | <input type="checkbox"/> Kneeling        |
| <input type="checkbox"/> Bending forward to brush teeth | <input type="checkbox"/> Balancing       |
| <input type="checkbox"/> Turning over in bed            | <input type="checkbox"/> Dressing self   |
| <input type="checkbox"/> Walking short distances        | <input type="checkbox"/> Sleeping        |
| <input type="checkbox"/> Standing for more than 1 hour  | <input type="checkbox"/> Stooping        |
| <input type="checkbox"/> Sitting at a table             | <input type="checkbox"/> Gripping        |
| <input type="checkbox"/> Lying on back                  | <input type="checkbox"/> Pushing         |
| <input type="checkbox"/> Lying flat on stomach          | <input type="checkbox"/> Pulling         |
| <input type="checkbox"/> Lying on side with knees bent  | <input type="checkbox"/> Reaching        |
| <input type="checkbox"/> Bending over forward           | <input type="checkbox"/> Sexual Activity |

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

Signature \_\_\_\_\_