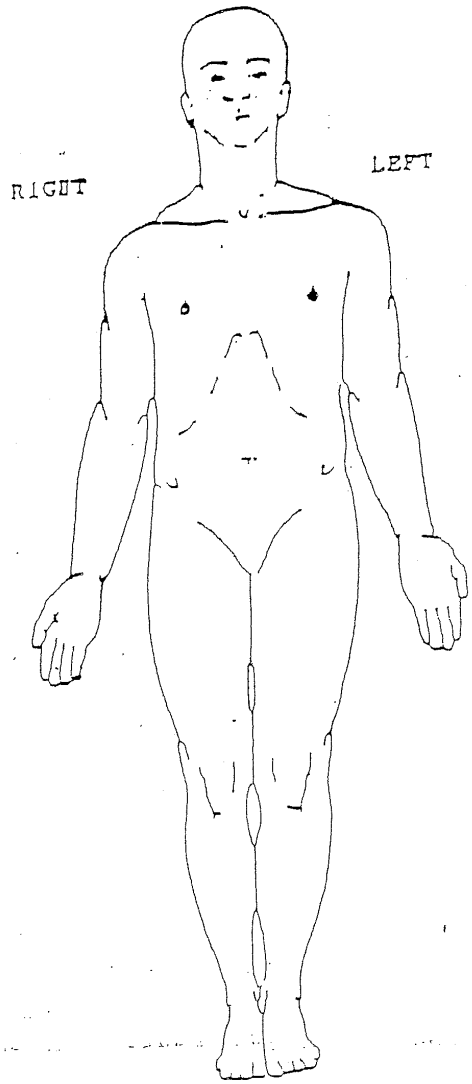
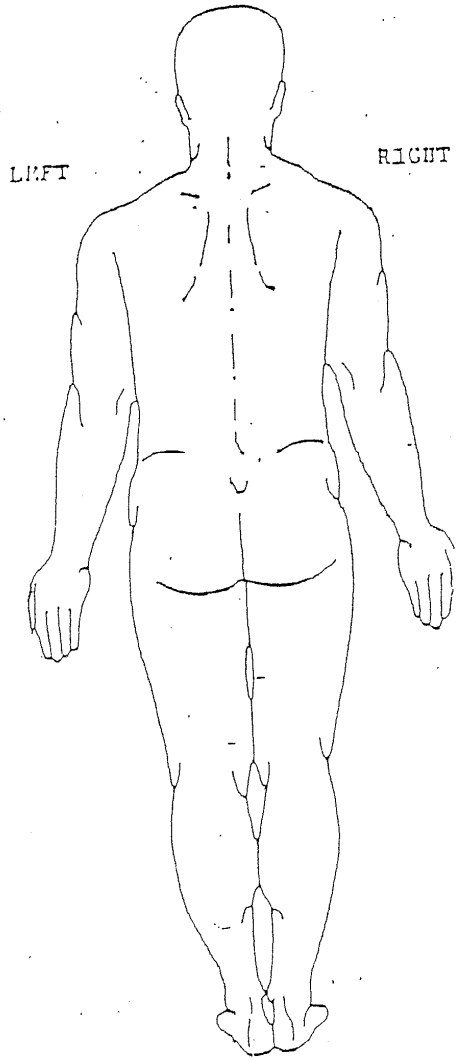
PLEASE INDICATE AREAS OF DISCOMFORT AS FOLLOWS:

CONSTANT PAIN _____ SOLID LINE

OCCASIONAL PAIN ---------- BROKEN LINE

NUMBNESS / TINGLING ..... SMALL DOTS





DATE _____ NAME _____

Please indicate your pain at its *BEST* and *WORST*

10	MAXIMAL	Unconscious. Pain makes you pass out.
9	VERY INTENSE	Unable to speak. Crying out or moaning uncontrollably.
8	INTENSE	Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set is as a factor.
7	VERY STRONG	Makes it difficult to concentrate. Interferes with sleep. You can still function with effort.
6	STRONG	Can't be ignored for any length of time, but you can still go to work and participate in social functions.
5	SOMEWHAT STRONG	Can't be ignored for more than 30 minutes.
4	MODERATE	Can be ignored if you are really involved in your work, but is still distracting.
3	VERY WEAK	Annoying enough to be distracting.
2	VERY, VERY WEAK	Minor annoyance – occasional strong twinge
1	SLIGHT	Very minor annoyance – less frequent strong twinges
0	NONE AT ALL	Pain free