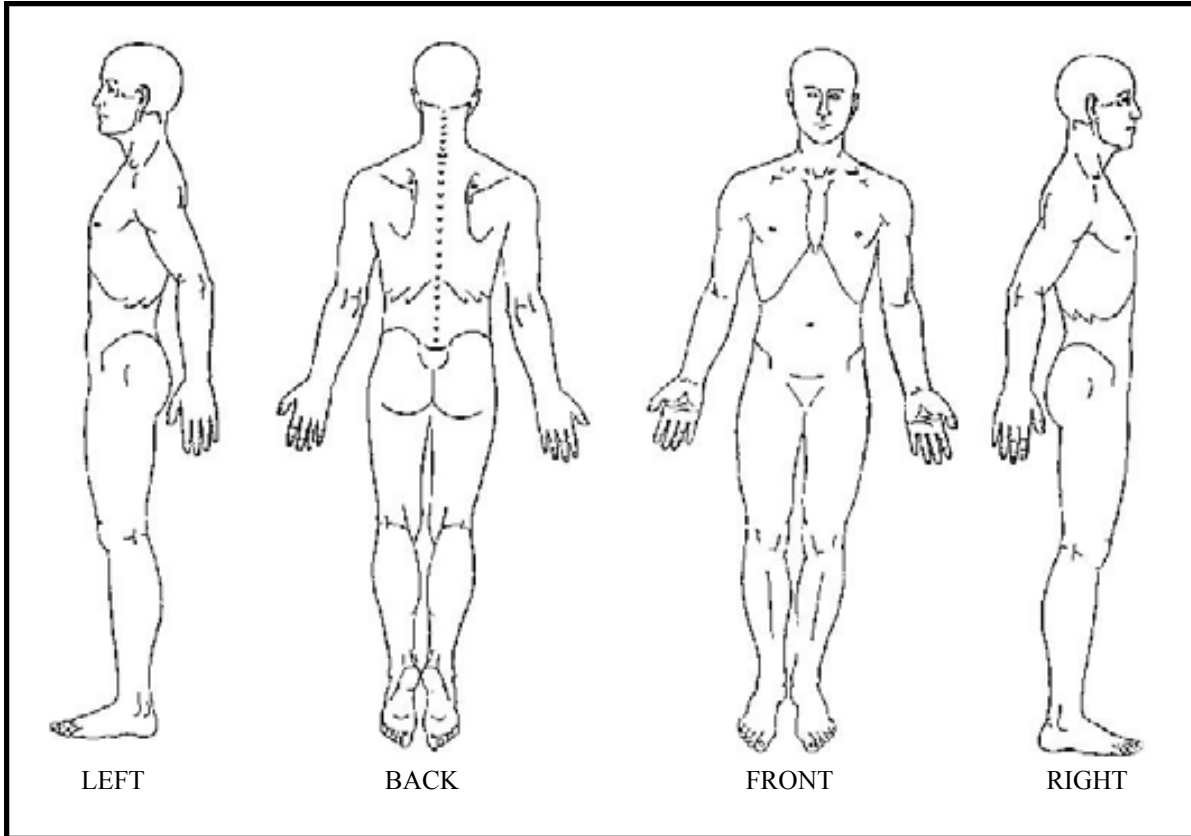


INITIAL PROBLEM RECORD

Name: _____

Date: _____

Please mark your areas of complaint on the diagrams below using the symbols on the right



Aching ^^^
Numbness +++
Pins and Needles 000
Burning xxx
Stabbing or Sharp ///
Scars, etc. —

What problem is your biggest concern? _____

On the horizontal line below, draw a vertical line (|) denoting the severity of your worst pain

No pain _____ Excruciating Pain

How many days a week do you experience this problem? (please circle one) 1 2 3 4 5 6 7

What percentage of the time do you experience this problem?(please circle one) <25% 25% 50% 75% 100%

If you have more than one problem, which is the next worst? _____

Rate this pain in a similar fashion:

No pain _____ Excruciating Pain

Signature

Date