

Name: _____

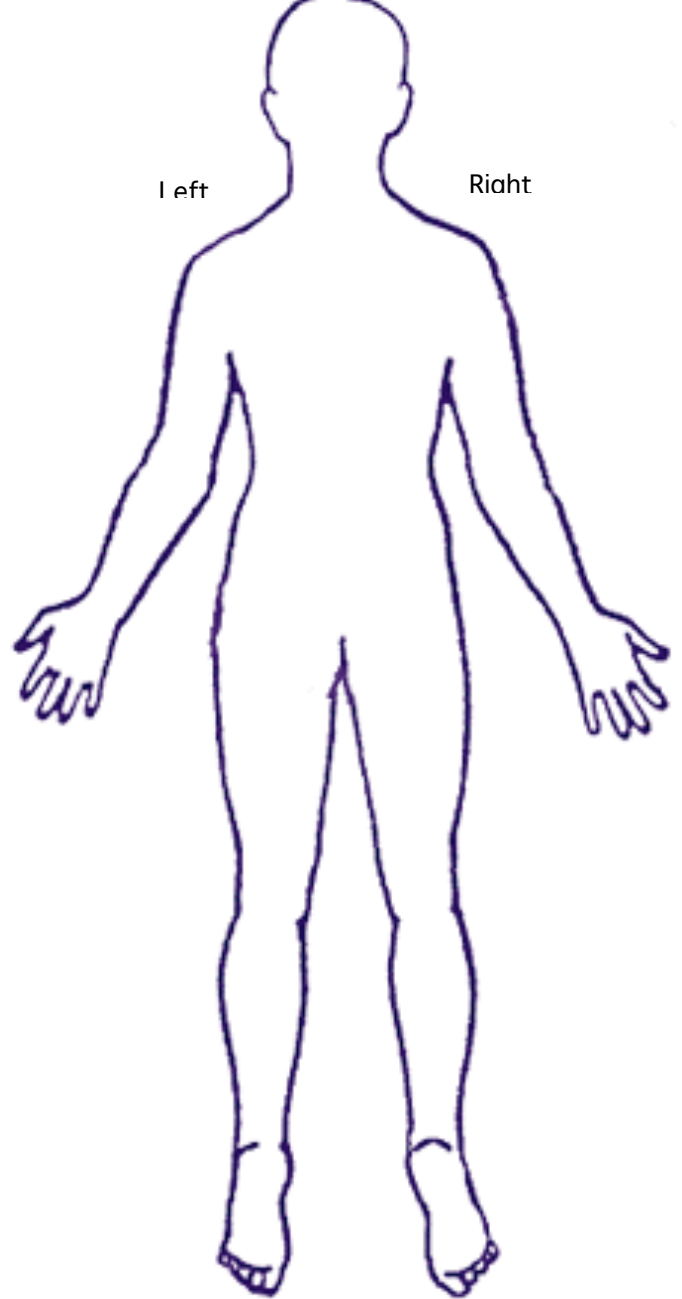
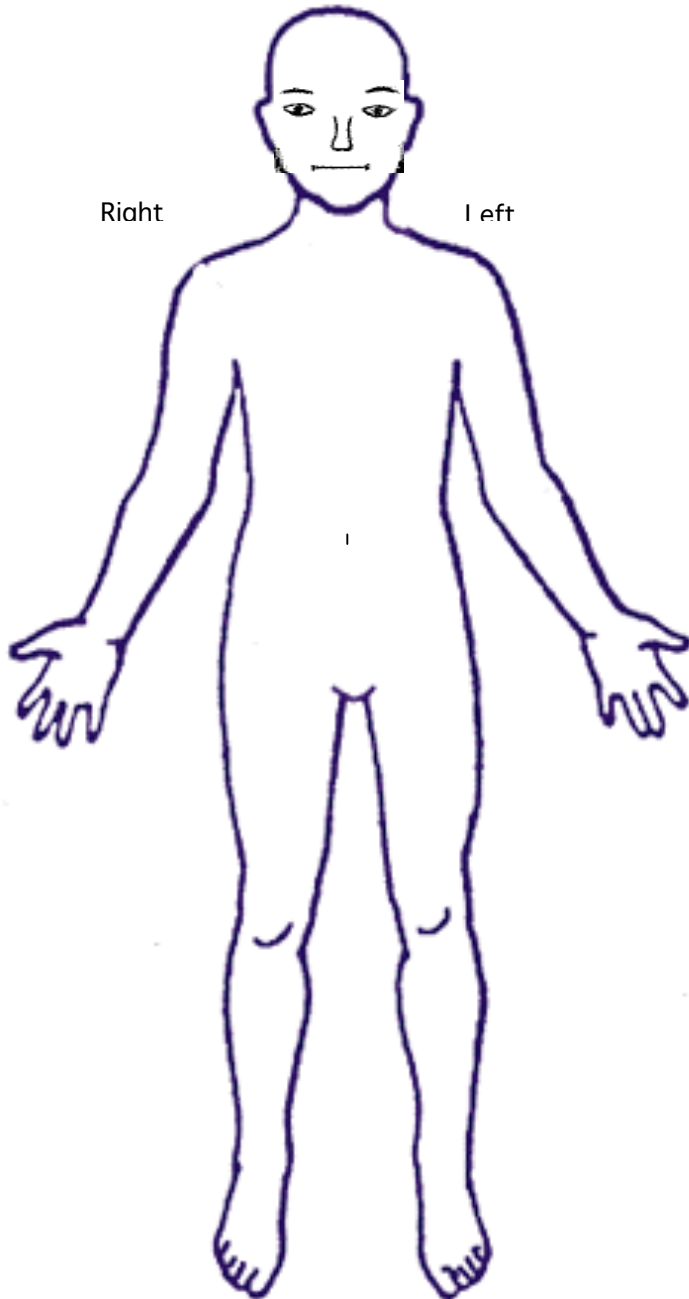
Date: _____

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

Numbness	====	Pins & Needles	oooo	Burning	xxxx	Stabbing	////	Ache	****
	====		oooo		xxxx		////		****
	====		oooo		xxxx		////		****

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