

## PAIN DRAWING

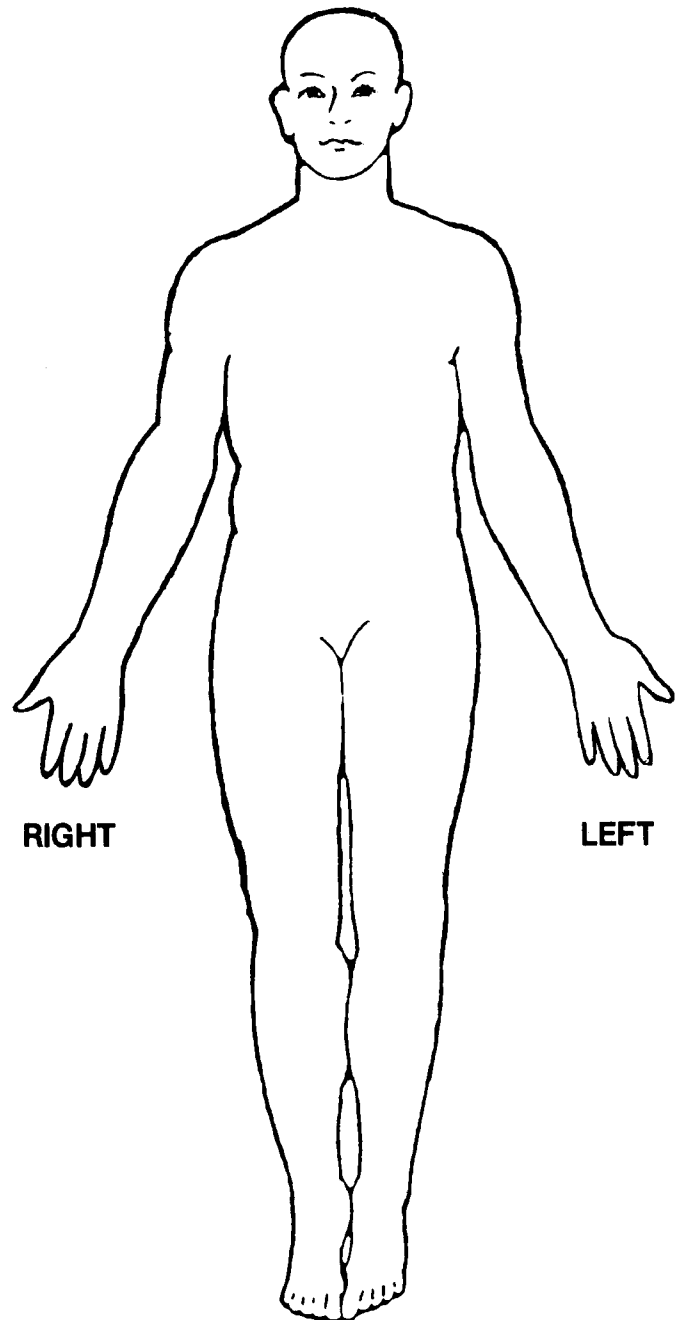
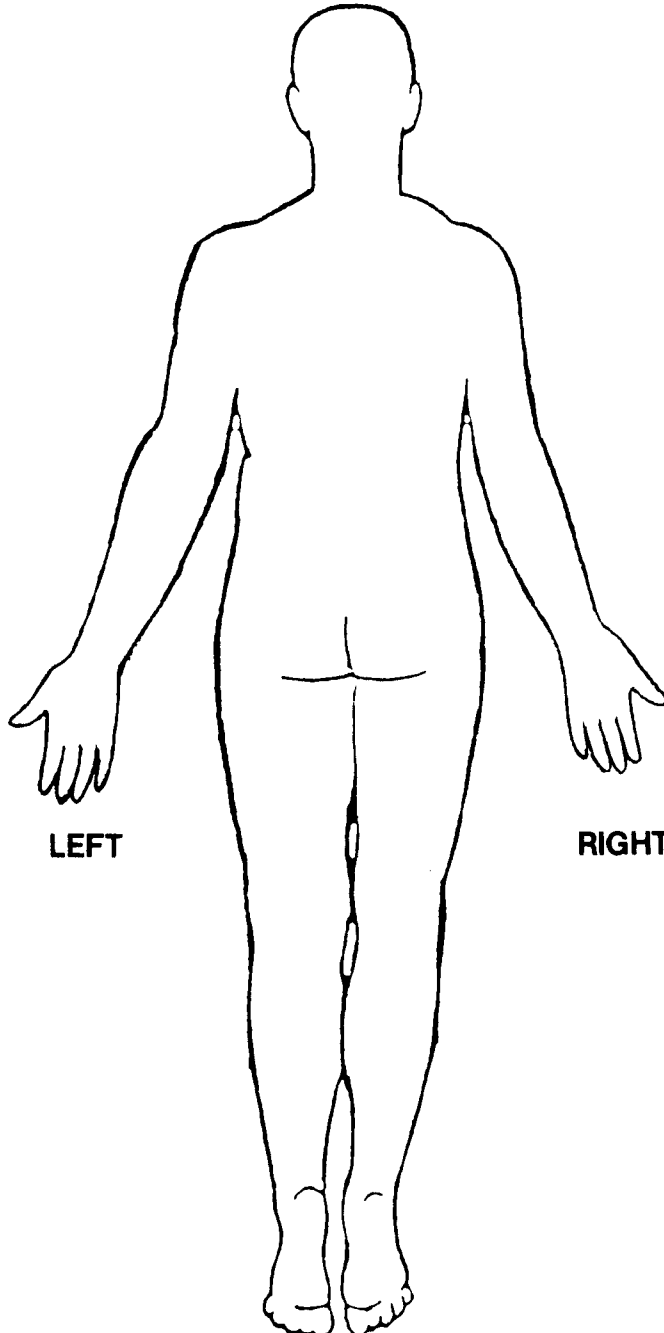
Name \_\_\_\_\_ Date \_\_\_\_\_

Be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

|          |       |         |      |         |       |          |      |        |      |
|----------|-------|---------|------|---------|-------|----------|------|--------|------|
|          | ===== | Pins &  | oooo | Burning | xxxxx | Stabbing | //// | Aching | (((( |
| Numbness | ===== |         | oooo |         | xxxxx |          |      |        |      |
|          | ===== | Needles | oooo | Pain    | xxxxx | Pain     | //// | Pain   | (((( |

### BACK

### FRONT



*Return to*

**MEMORIAL ORTHOPAEDIC  
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