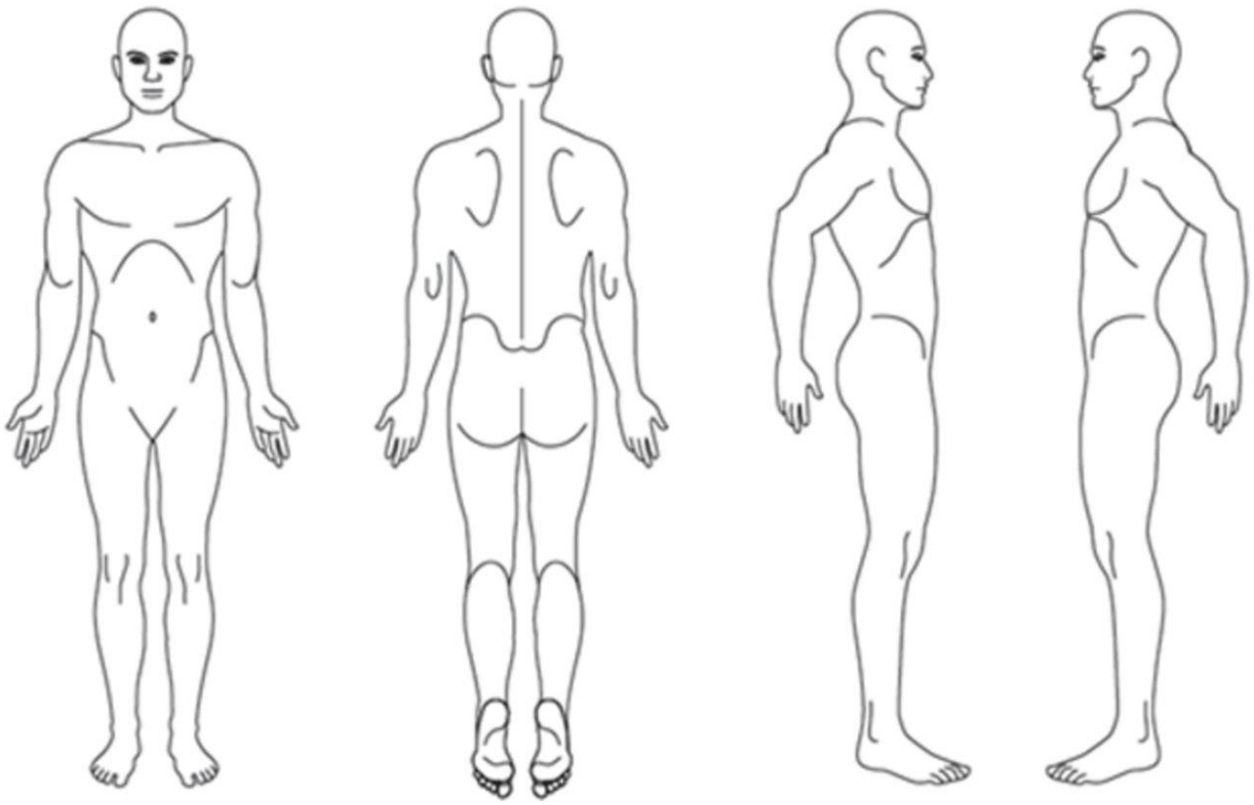
DAILY PAIN DRAWING

Please mark on the figures below where your pain or other symptoms are.

Front View | Back View | Right Side | Left Side



Please indicate your pain level from 0 to 10.

Mild			Moderate				Severe			Very Severe
0	1	2	3	4	5	6	7	8	9	10

Your Signature:	Date: