WEST END
ORTHOPAEDIC
CLINIC

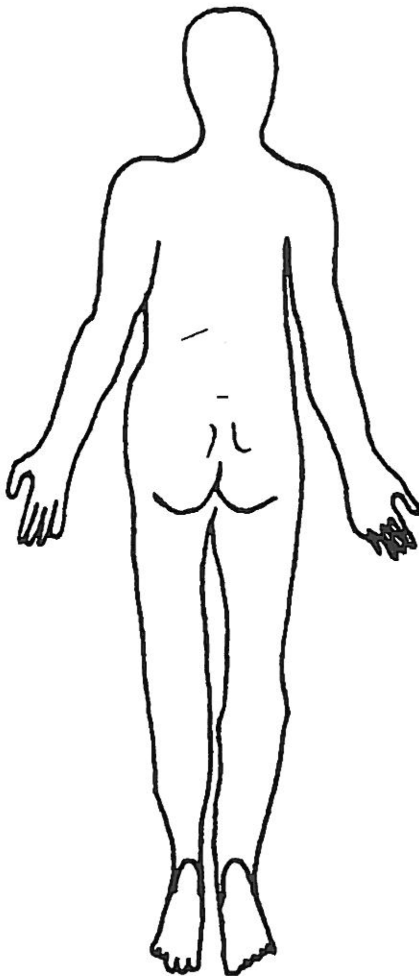
BACK FORM

PATIENT:

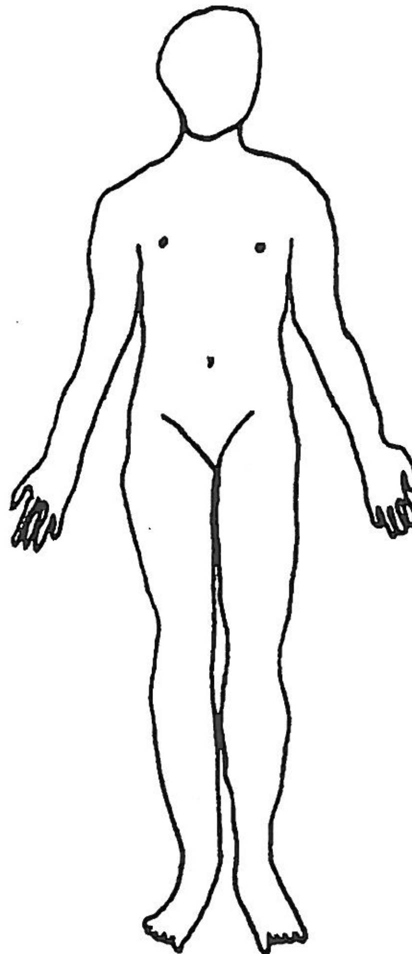
DATE:

MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS APPLY.
USE THE APPROPRIATE SYMBOL. MARK AREAS OF RADIATION. INCLUDE ALL AFFECTED AREAS.

NUMBNESS:	======	***PINS & NEEDLES:***	000000	***PAIN:***	XXXXXX	***ACHING:***	//////
	======		000000		XXXXXX		//////



BACK



FRONT