Name: ____
Date: ______________________________

Please describe each symptom separately that you marked on the figure sheet.

1) What is your symptom and when did you first feel your symptom?
____
What positions, movements or actions increase your symptom?
____
What positions, movements or actions reduce your symptom?
____
Describe your symptom. Burning, numbness, tingling, aching, sharp, etc.
____
Does your symptom radiate to other body areas? If so, where?
____
Rate your symptom from 1-10 with 10 be worst. 6 means your symptoms limits you in some way. ____
Is your symptom worse at any time of day? If so when. __________________________

2) What is your symptom and when did you first feel your symptom?
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What positions, movements or actions increase your symptom?
____
What positions, movements or actions reduce your symptom?
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Describe your symptom. Burning, numbness, tingling, aching, sharp, etc.
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Does your symptom radiate to other body areas? If so, where?
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Rate your symptom from 1-10 with 10 be worst. 6 means your symptoms limits you in some way. ____
Is your symptom worse at any time of day? If so when. __________________________

3) What is your symptom and when did you first feel your symptom?
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What positions, movements or actions increase your symptom?
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Describe your symptom. Burning, numbness, tingling, aching, sharp, etc.
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Does your symptom radiate to other body areas? If so, where?
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Rate your symptom from 1-10 with 10 be worst. 6 means your symptoms limits you in some way. ____
Is your symptom worse at any time of day? If so when. __________________________

Name: ____
Date: _______________________________

Please describe each symptom separately that you marked on the figure sheet.

4) What is your symptom and when did you first feel your symptom?
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What positions, movements or actions increase your symptom?
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What positions, movements or actions reduce your symptom?
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Describe your symptom. Burning, numbness, tingling, aching, sharp, etc.
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Does your symptom radiate to other body areas? If so, where?
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Rate your symptom from 1-10 with 10 be worst. 6 means your symptoms limits you in some way. ____
Is your symptom worse at any time of day? If so when. ____________________________

5) What is your symptom and when did you first feel your symptom?
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What positions, movements or actions increase your symptom?
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What positions, movements or actions reduce your symptom?
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Describe your symptom. Burning, numbness, tingling, aching, sharp, etc.
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Does your symptom radiate to other body areas? If so, where?
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Rate your symptom from 1-10 with 10 be worst. 6 means your symptoms limits you in some way. ____
Is your symptom worse at any time of day? If so when. ____________________________

6) What is your symptom and when did you first feel your symptom?
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What positions, movements or actions increase your symptom?
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What positions, movements or actions reduce your symptom?
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Describe your symptom. Burning, numbness, tingling, aching, sharp, etc.
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Does your symptom radiate to other body areas? If so, where?
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Rate your symptom from 1-10 with 10 be worst. 6 means your symptoms limits you in some way. ____
Is your symptom worse at any time of day? If so when. ____________________________

Name: ____
Date: ________________________________

Please describe each symptom separately that you marked on the figure sheet.

7) What is your symptom and when did you first feel your symptom?
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What positions, movements or actions increase your symptom?
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What positions, movements or actions reduce your symptom?
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Describe your symptom. Burning, numbness, tingling, aching, sharp, etc.
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Does your symptom radiate to other body areas? If so, where?
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Rate your symptom from 1-10 with 10 be worst. 6 means your symptoms limits you in some way. ____
Is your symptom worse at any time of day? If so when. ____________________________

8) What is your symptom and when did you first feel your symptom?
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What positions, movements or actions increase your symptom?
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What positions, movements or actions reduce your symptom?
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Describe your symptom. Burning, numbness, tingling, aching, sharp, etc.
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Does your symptom radiate to other body areas? If so, where?
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Rate your symptom from 1-10 with 10 be worst. 6 means your symptoms limits you in some way. ____
Is your symptom worse at any time of day? If so when. ____________________________

9) What is your symptom and when did you first feel your symptom?
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What positions, movements or actions increase your symptom?
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What positions, movements or actions reduce your symptom?
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Describe your symptom. Burning, numbness, tingling, aching, sharp, etc.
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Does your symptom radiate to other body areas? If so, where?
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Rate your symptom from 1-10 with 10 be worst. 6 means your symptoms limits you in some way. ____
Is your symptom worse at any time of day? If so when. ____________________________