

# SYMPTOM DIAGRAM

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

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches ^^^^

Numbness oooo

Pins/Needles ●●●●

Burning xxxx

Stabbing ///

