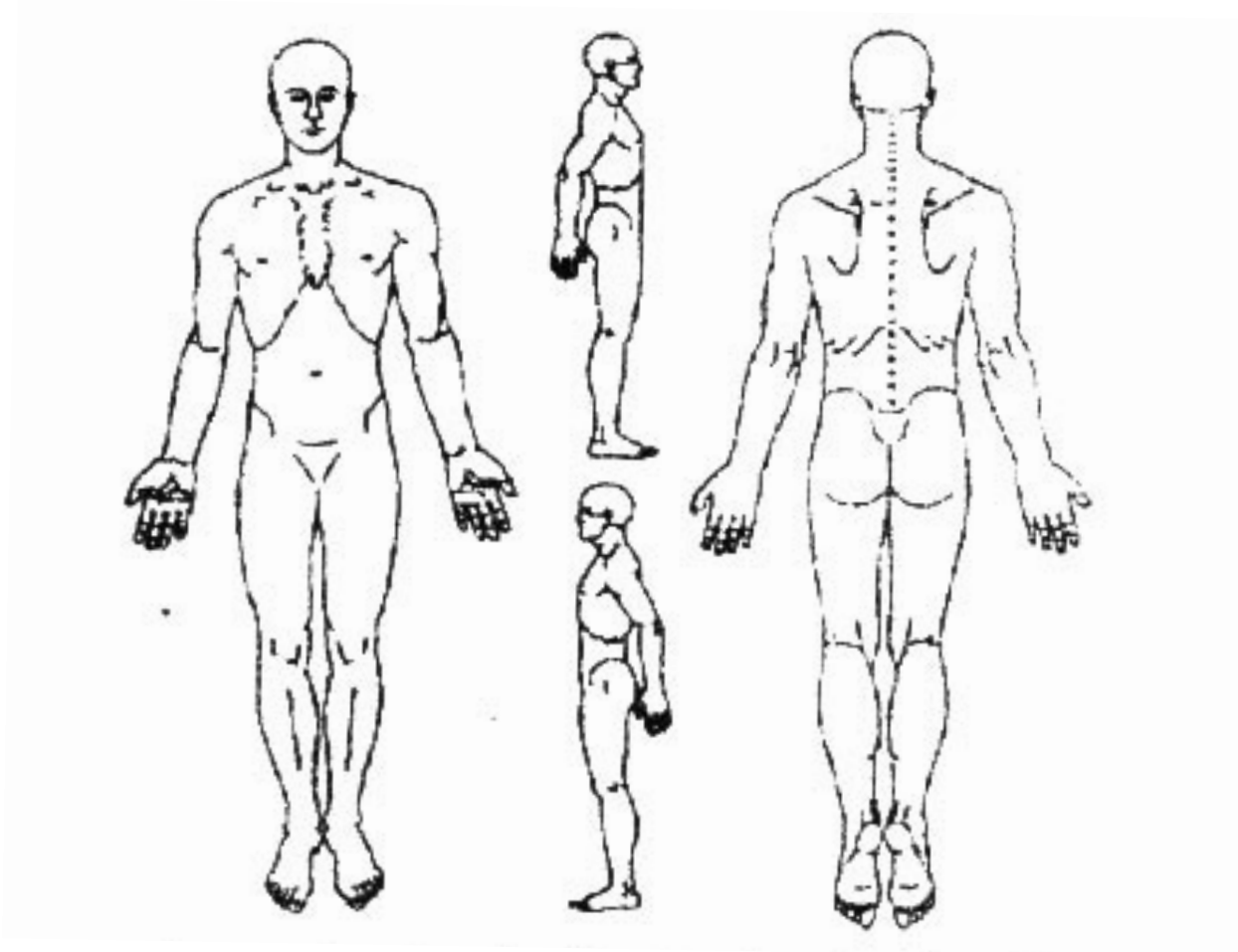


If there is a pain, please indicate the location and pain level you have right now.



0 1 2 3 4 5 6 7 8 9 10  
No pain Highest pain

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_