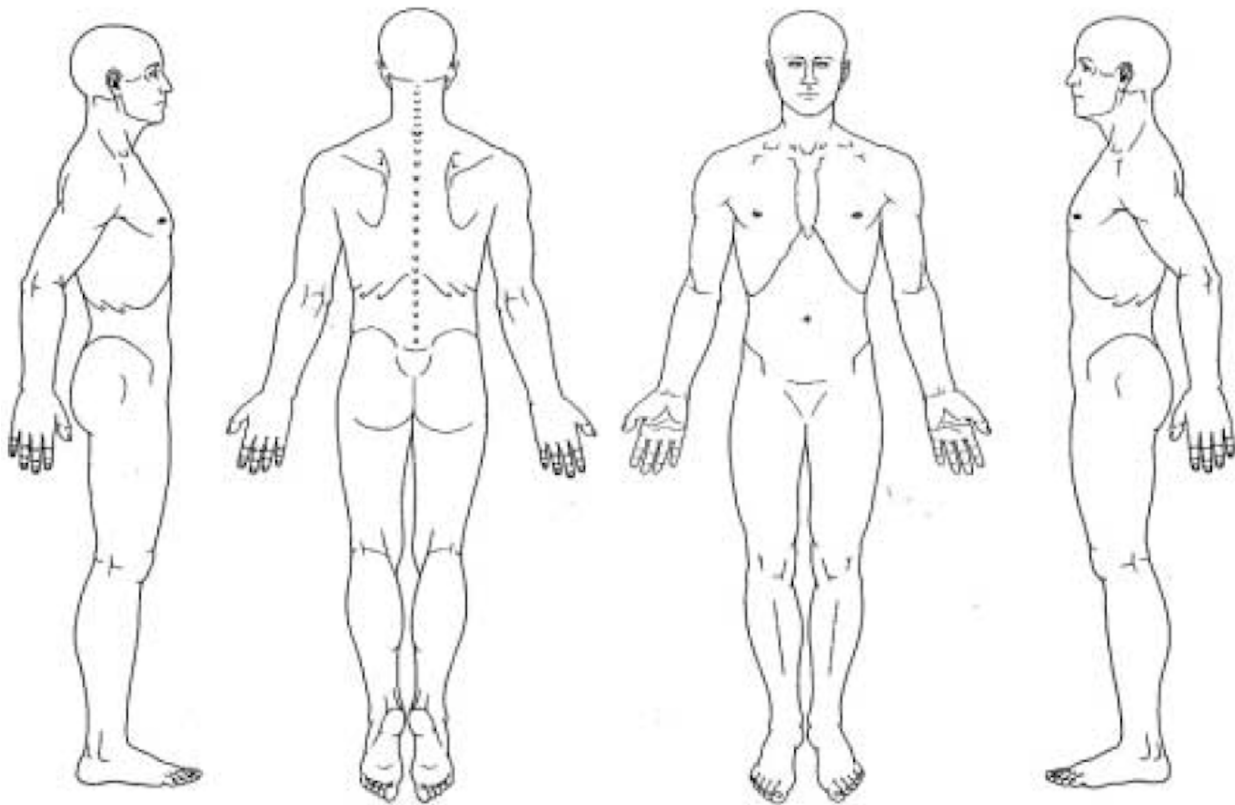




Please mark an X to indicate the areas where you feel pain, swelling, numbness or discomfort. Describe in your own words what you feel or observe.



Please use the space below to describe your condition further, if needed:

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Date: \_\_\_\_\_

Signature: \_\_\_\_\_