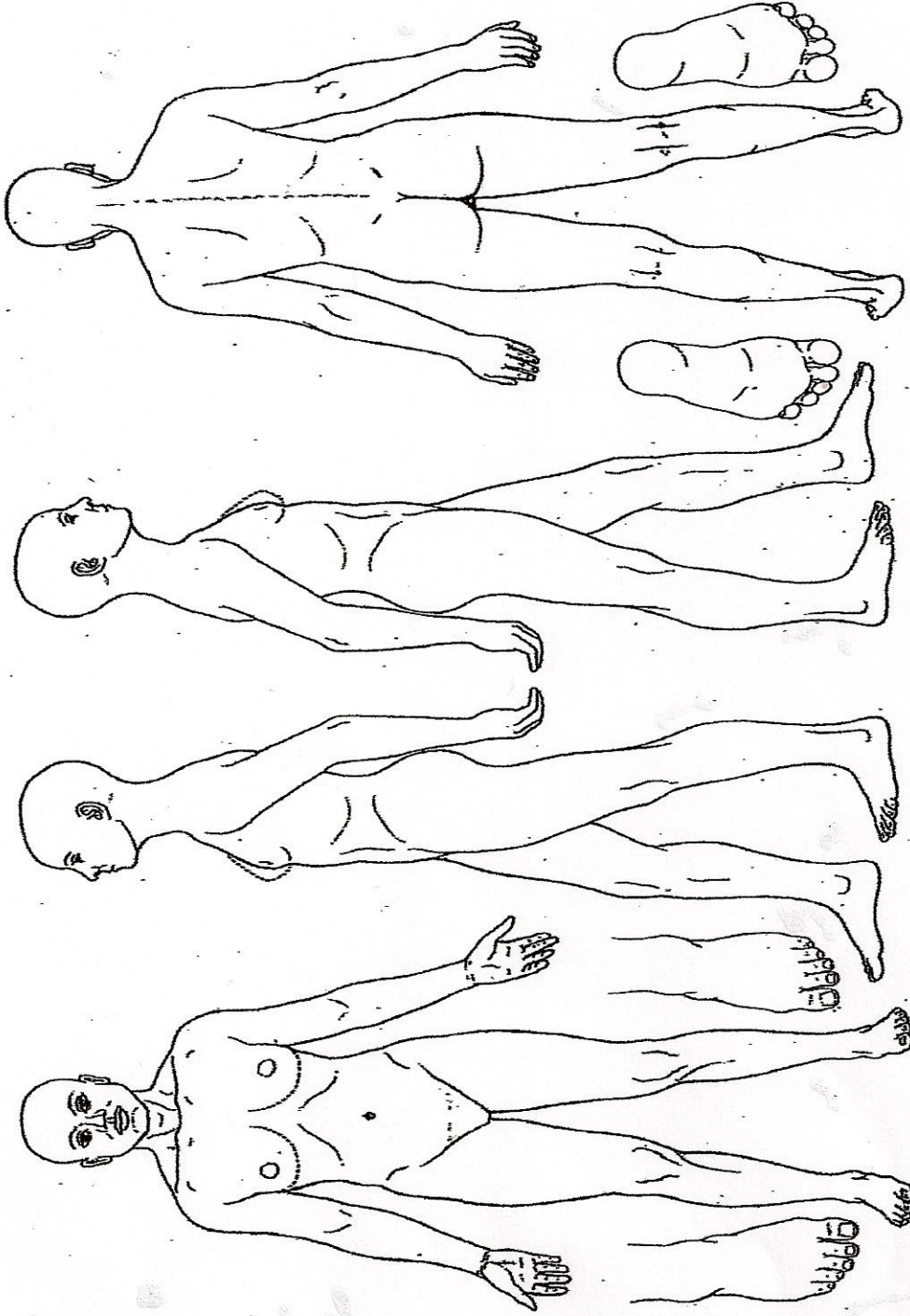


PLEASE CIRCLE ANY SPECIFIC AREAS OF PAIN AND/OR TENSION THAT YOU ARE EXPERIENCING.



PRINT PATIENTS NAME: \_\_\_\_\_

PATIENTS SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_