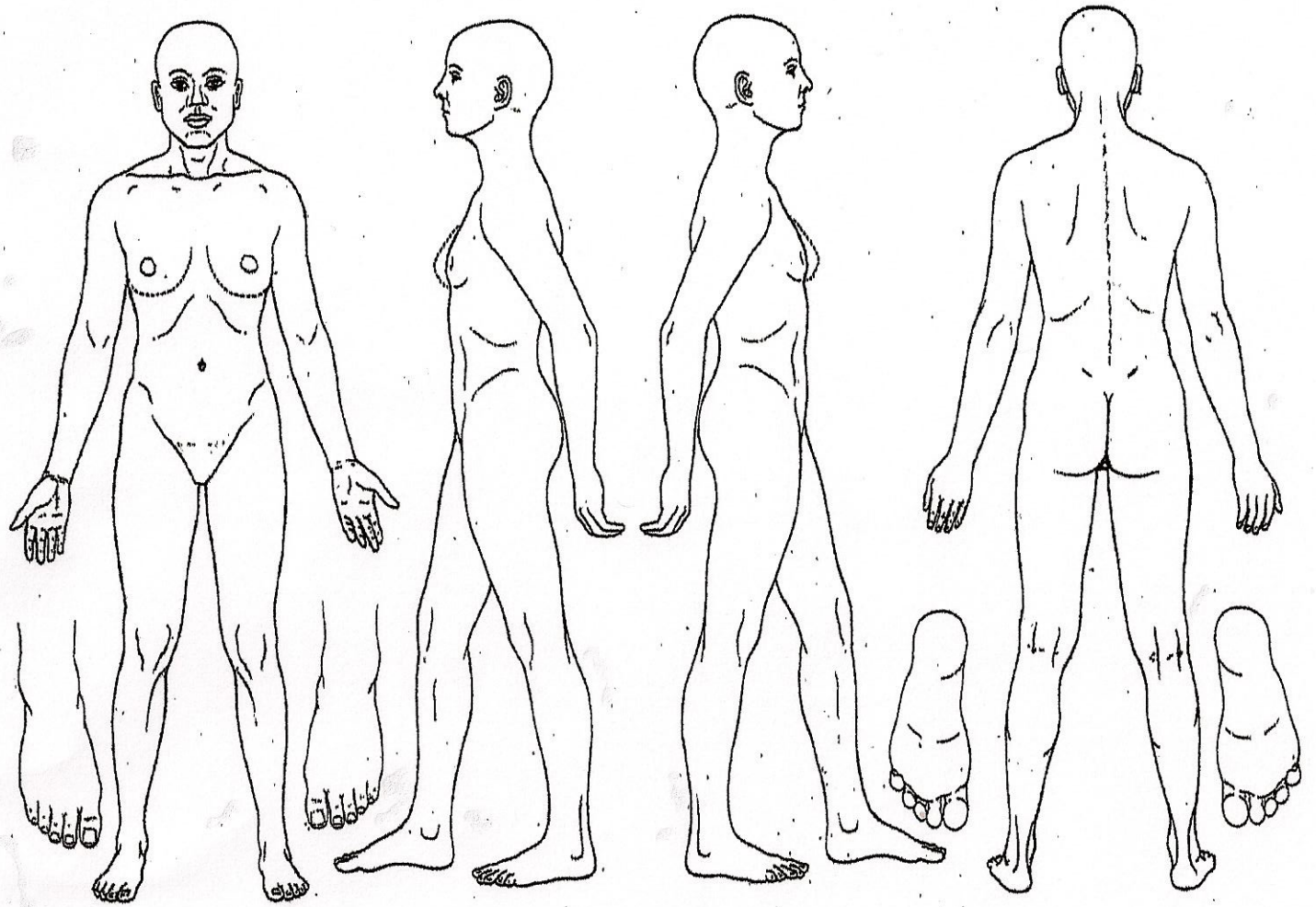
PLEASE CIRCLE ANY SPECIFIC AREAS OF PAIN AND/OR TENSION THAT YOU ARE EXPERIENCING.



PRINT PATIENTS NAME: _____ **PATIENTS SIGNATURE:** _____ **DATE:** _____