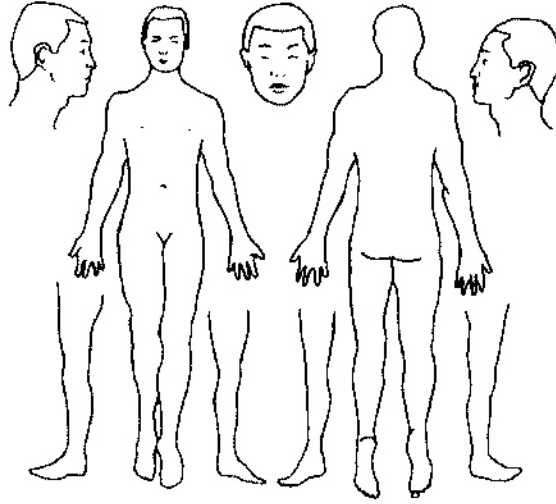


Indicate painful or distressed areas:



I have completed this form correctly to the best of my knowledge.

Signature:

Adult Patient Parent or Guardian Spouse