9

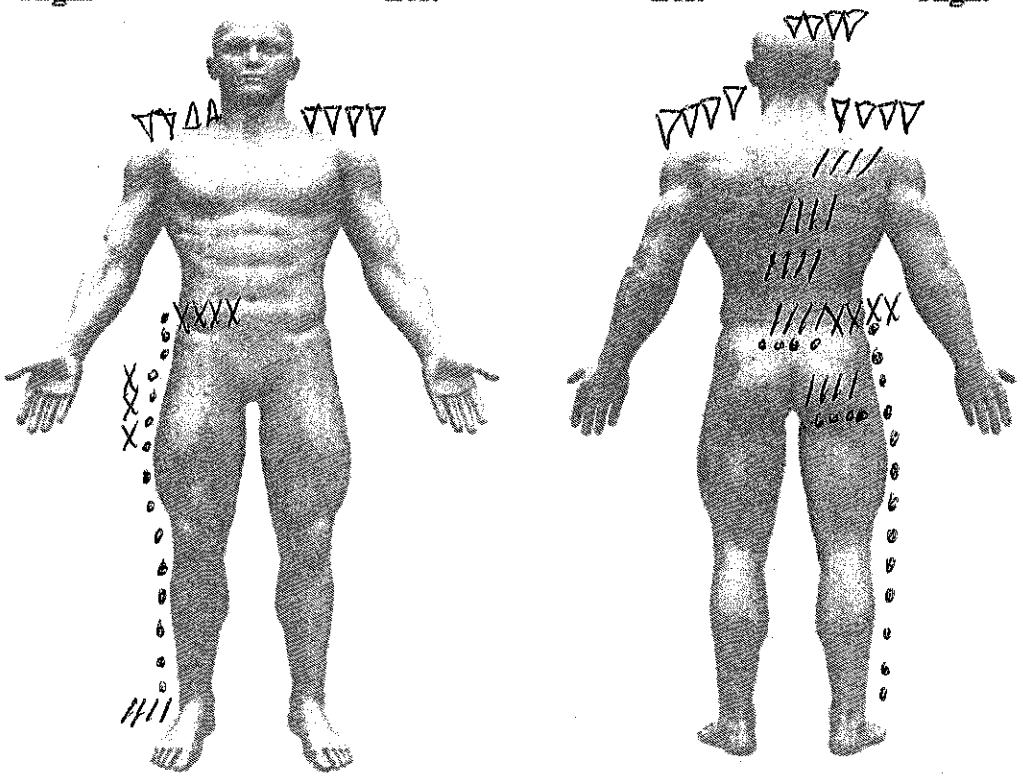
Injury Care Network, LLC

Provider **WALLACE D.O.**
Patient **ANGEL, THEODORE**
DOB **09/15/1975** DOL **02/23/2023**
DOS **03/10/2023**

Please mark all areas of pain with the symbols below.

▽ ▽ ▽ ▽ ACHING = = = = NUMBNESS • • • • PINS & NEEDLES X X X X BURNING //// STABBING

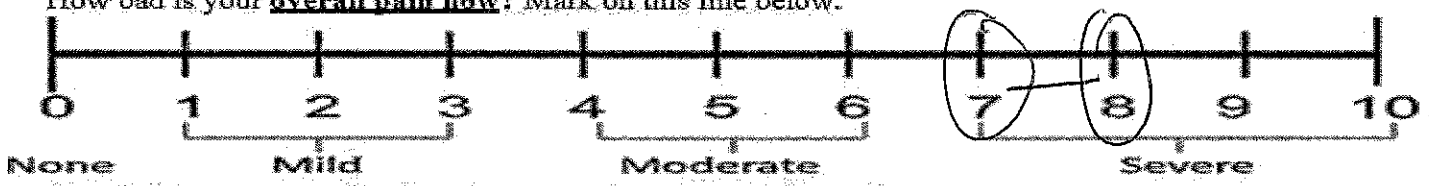
Right Left Left Right



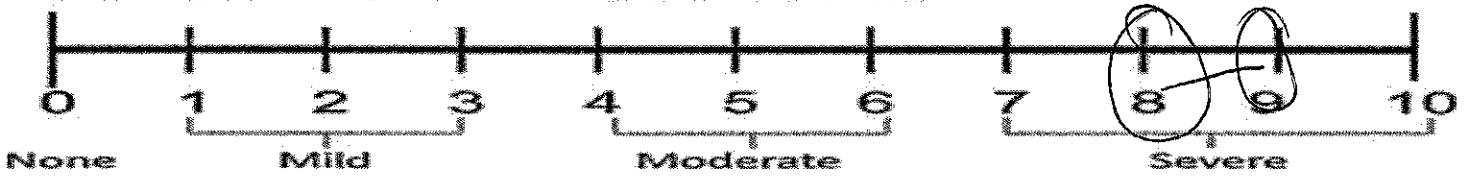
DO YOU HAVE ANY OF THE FOLLOWING:

- ☐ Loss of Bowel/ Bladder Function
- ☐ Dizziness/Light Headed
- ☐ Vision Changes (Blurred/Double)
- ☐ Headache (Draw on person)
- ☐ None

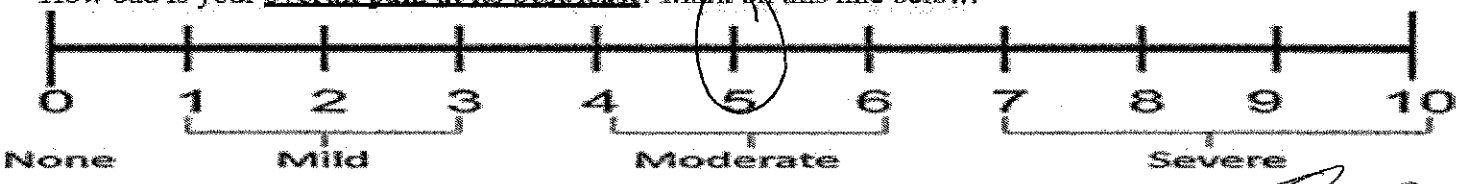
How bad is your **overall pain now**? Mark on this line below.



How bad is your **overall pain at its worst**? Mark on this line below.



How bad is your **overall pain at its best/least**? Mark on this line below.



Signature: _____ Date: 03/10/23