

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.

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 ACHING NUMBNESS PINS & NEEDLES BURNING STABBING

Right

Left

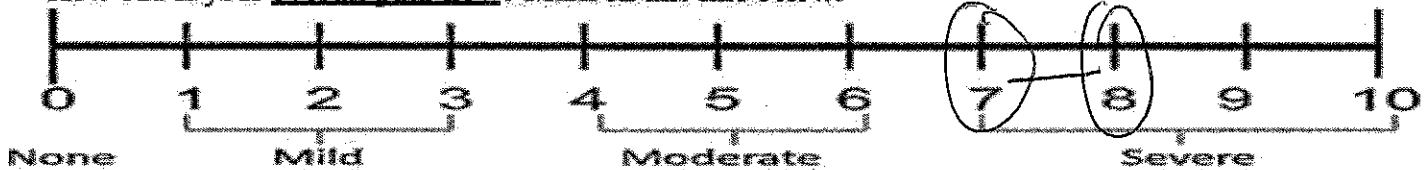
Left

Right

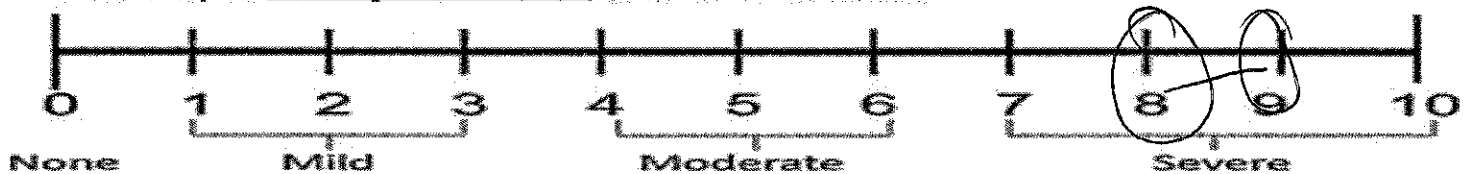
DO YOU HAVE ANY OF THE FOLLOWING:

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

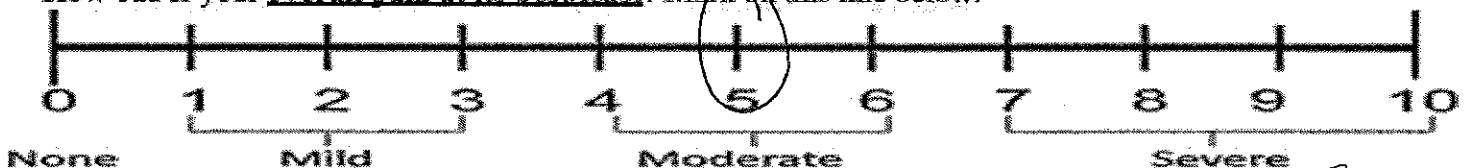
How bad is your **overall pain now**? Mark on this line below.



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**

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