Dato:											
Date:											
Name:											
Telephone No.:											
Email Address:											
Date of Birth:											
Occupation:											
Pain relating to:											
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How long have you ha	ad th	is p	ain:								
Please circle relevant nu	mbei		O = I	No Pa	ain,	10 =	= Wc	orst I	Pain	Ever	•
Worst Pain Level:	0	1	2	3	4	5	6	7	8	9	10
Pain level on <u>arrival</u> :	0	1	2	3	4	5	6	7	8	9	10
Pain level at <u>end</u> :	0	1	2	3	4	5	6	7	8	9	10
Comments on your ex	perie	ence	<u>)</u> :								
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Signature:											
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For Training Purposes					For	Marl	ketir	ng P	urp	oses	; 🔲
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Date:					-						
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Pain level on <u>arrival</u> :	0	1	2	3	4	5	6	7	8	9	10
Pain level at <u>end</u> :	0	1	2	3	4	5	6	7	8	9	10
Comments on your ex	perie	ence	<del>5</del> :								
Signature:											
Permission to use vide	eo (w	her	е ар	plica	able	):					
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