

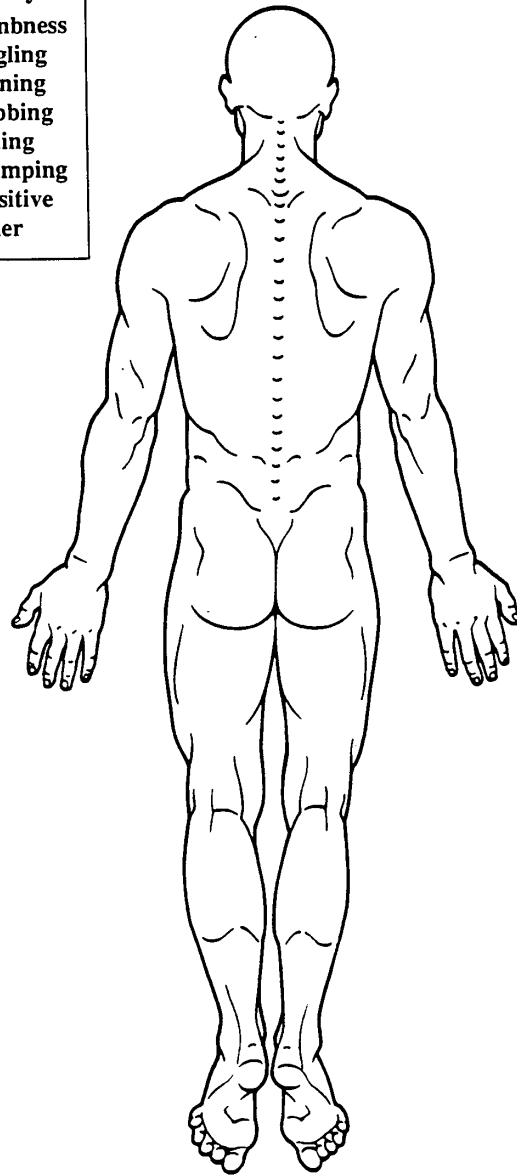
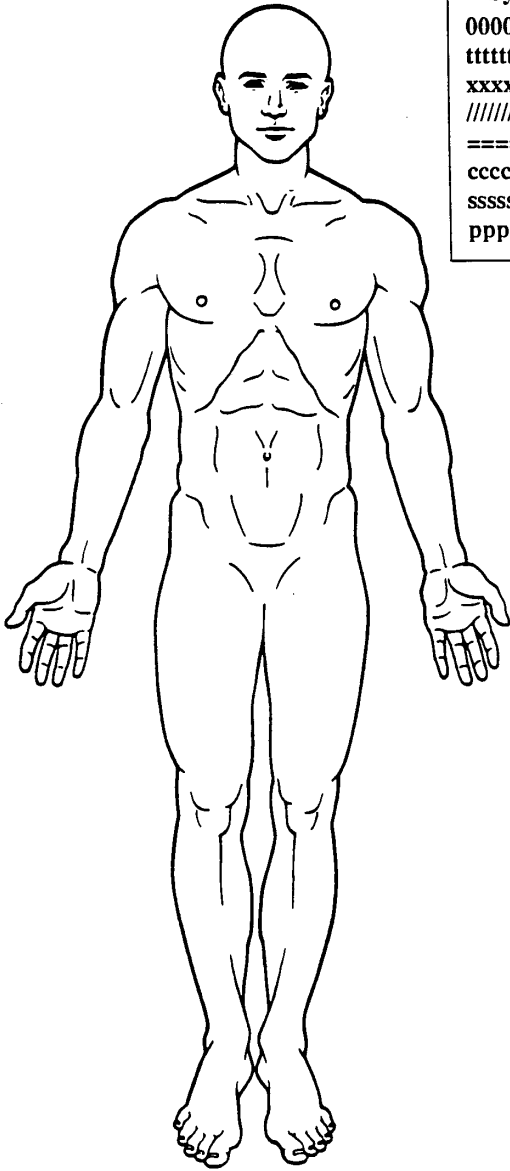
Name _____

Date _____

WHOLE BODY SYMPTOM DESCRIPTION

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Symptom Key	
0000	Numbness
ttttt	Tingling
xxxx	Burning
/////	Stabbing
=====	Aching
ccccc	Cramping
sssss	Sensitive
pppp	Other

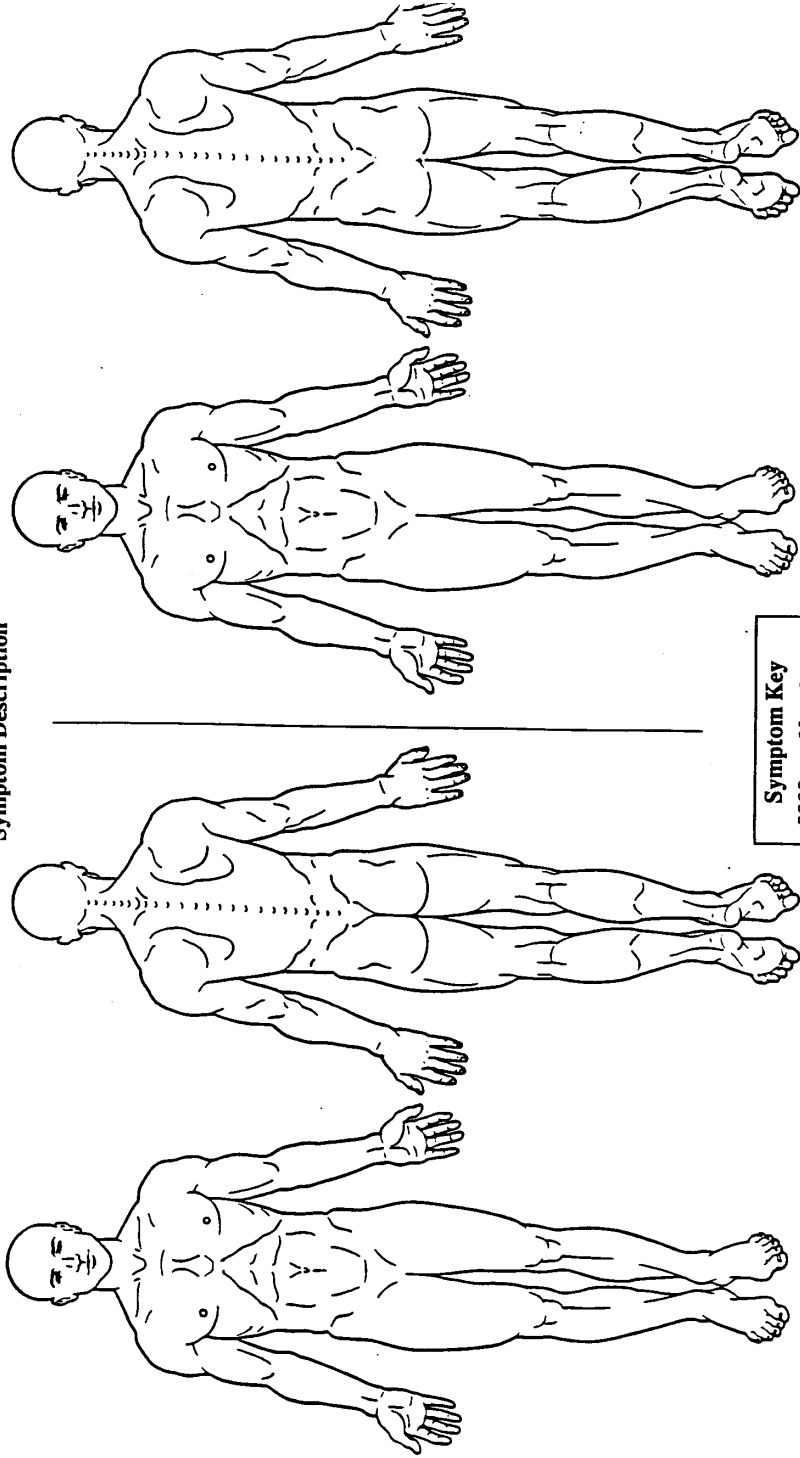


Use scale above to rate your highest level of pain in each area over the past week.

Appendix D

CALIFORNIA FUNCTIONAL CAPACITY PROTOCOL

Symptom Description



Symptom Key	
0000	Numbness
ttttt	Tingling
xxxxx	Burning
/////	Stabbing
=====	Aching
cccccc	Cramping
ppppp	Other

How bad is your pain now?

no pain | | | | | worst possible

Time: _____

How bad is your pain now?

no pain | | | | | worst possible

Name _____

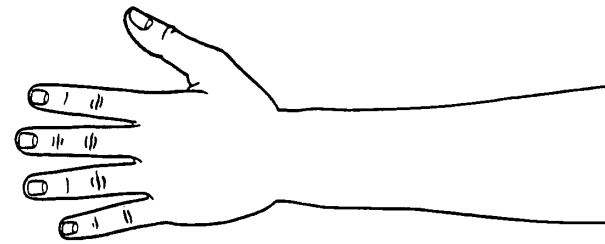
Date _____

HAND SYMPTOM DESCRIPTION

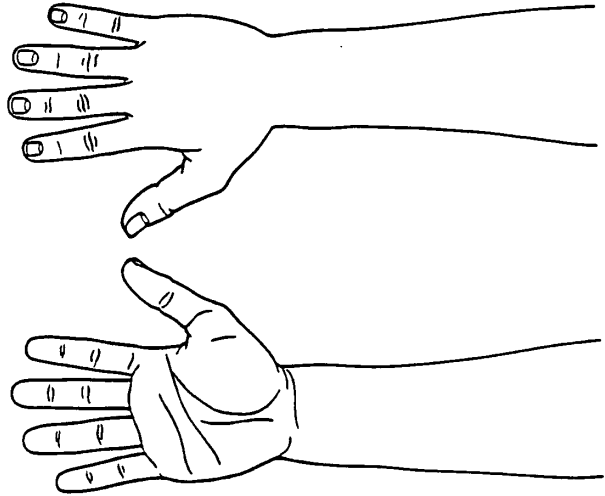
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Symptom Key	
0000	Numbering
ttttt	Tingling
xxxx	Burning
/////	Stabbing
====	Aching
cccc	Cramping
ssss	Sensitive
pppp	Other

LEFT HAND



RIGHT HAND



no pain

worst possible

no pain

worst possible

Use scale above to rate your highest level of pain in each area over the past week.

Appendix E