Date: ___

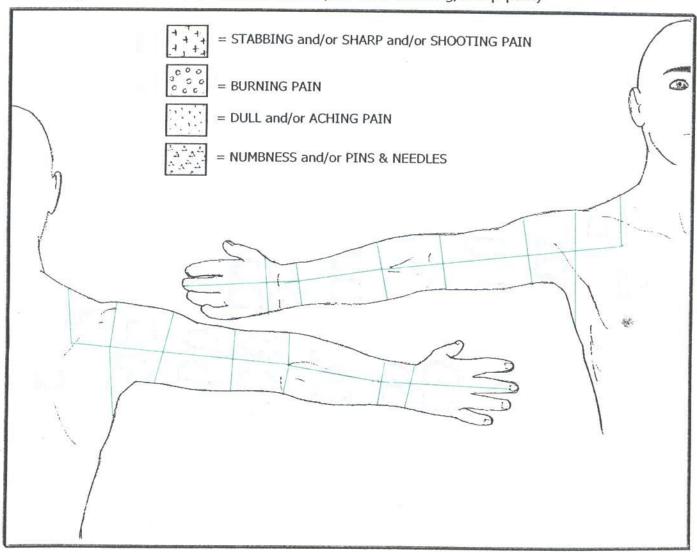


Shoulder Pain Radiation Form

ame:	*
ate of Birth:	Hospital Number:
ex: M / F	
3	te of Birth:

guide below:

(eg. draw an area of crosses where you have stabbing/sharp pain)



Indicate on this line how bad your pain is – at the end of the line means no pain at all, at the right end of the line means worst pain possible

No	Worst Pain
Pain	Possible