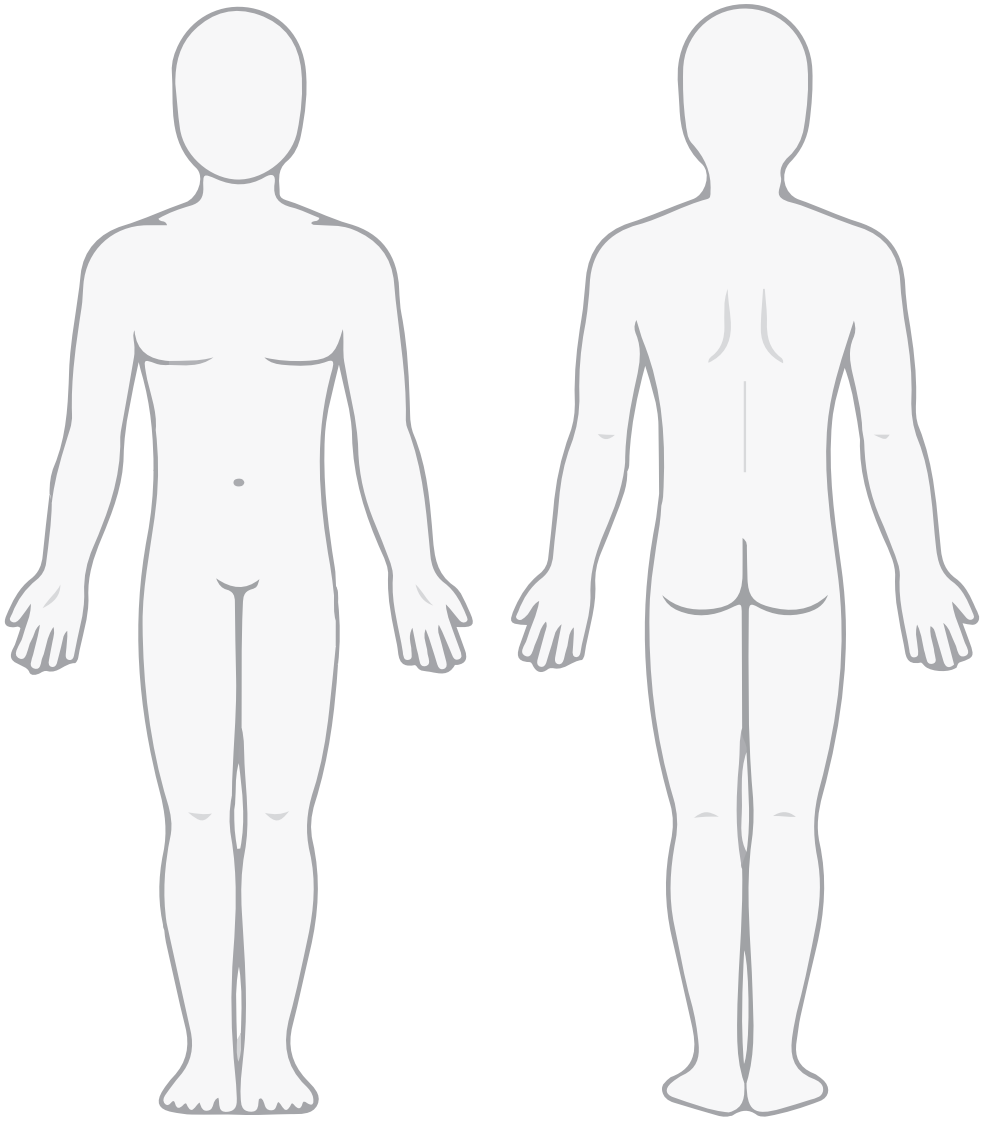
PAIN CHART

Please indicate below where your symptoms are located.



If you are having pain, please rate the intensity of your pain on a scale of 0-10, with 0 being no pain, and 10 being the worst pain.

Pain Intensity:_____

Athlete Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Therapist Signature:_____ Date:_____

484.367.7633 • c4perform.com • mike@c4perform.com

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