

<b>FOREARM</b>	
Location	<input type="checkbox"/> Right Forearm <input type="checkbox"/> Left Forearm <input type="checkbox"/> Both Forearms
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50%  <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain  Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling  <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Bruises <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity  <input type="checkbox"/> Weakness <input type="checkbox"/> Burns <input type="checkbox"/> Abrasions
Radiates to	<input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Elbow <input type="checkbox"/> Left Elbow  <input type="checkbox"/> Right Forearm <input type="checkbox"/> Left Forearm <input type="checkbox"/> Right Hand <input type="checkbox"/> Left Hand  <input type="checkbox"/> Right Fingers <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Left Fingers <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At its worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night  After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting  <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Grasping <input type="checkbox"/> Housework <input type="checkbox"/> Lifting <input type="checkbox"/> Driving <input type="checkbox"/> Working