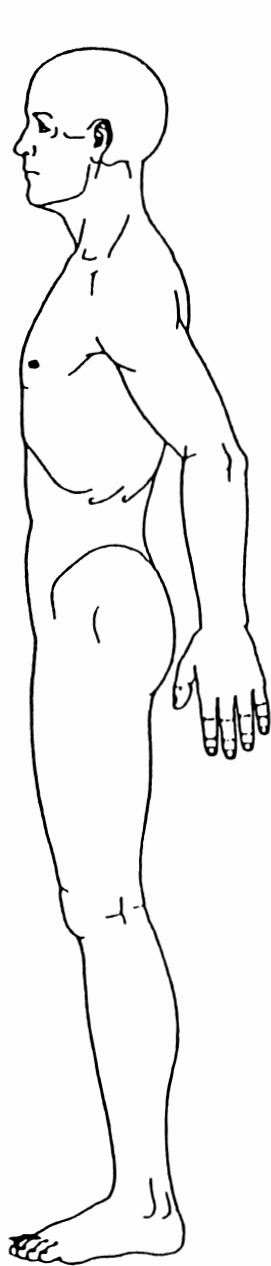
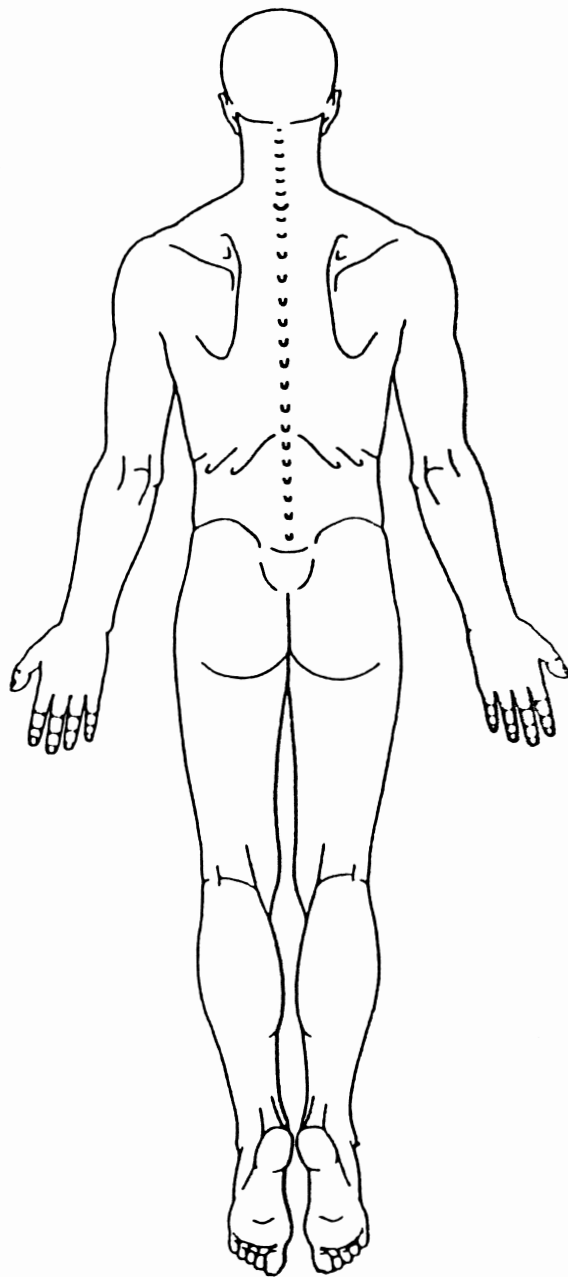


# THE EDMUND CENTER OF NEUROMUSCULAR & MASSAGE THERAPY

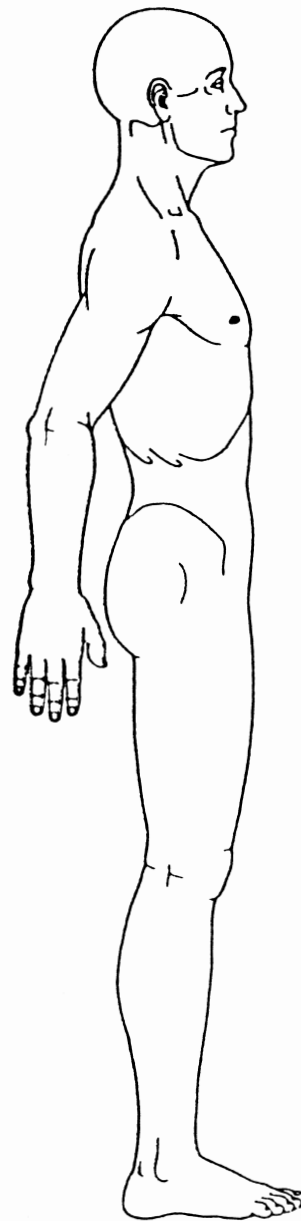
Name \_\_\_\_\_ Date \_\_\_\_\_ Please Indicate ALL areas in which you experience PAIN



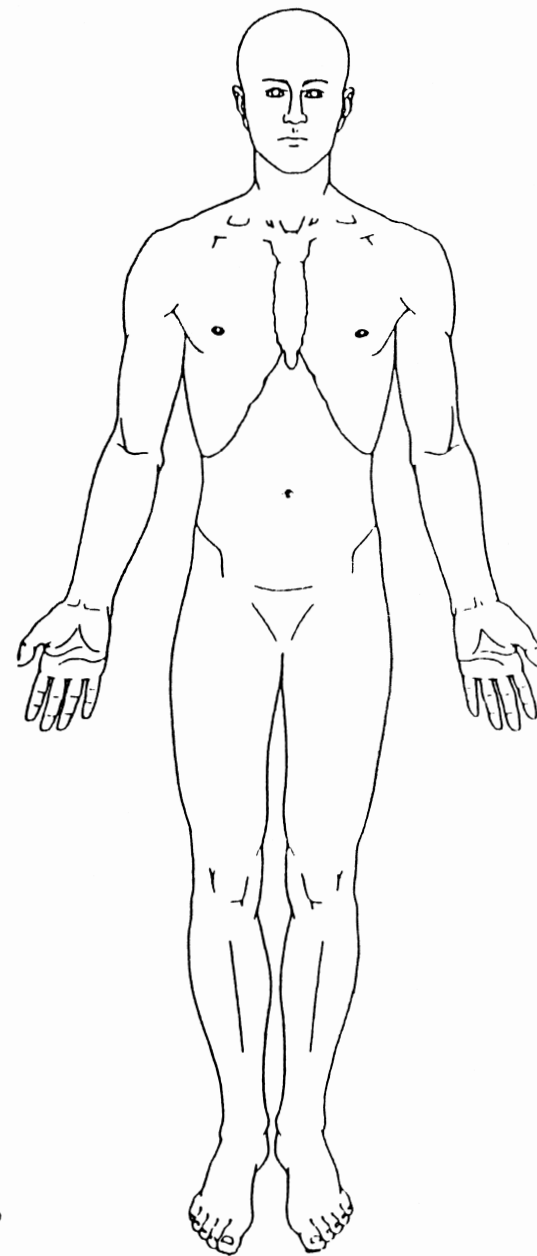
LEFT



BACK



RIGHT



FRONT