THE BRESLER CENTER FOR MIND/BODY MEDICINE

Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or in the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: David Bresler, PhD, LAc, c/o Eric, Office Manager, 1800 Thayer Ave, Unit A, LA, CA 90025 310-474-2777.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: David Bresler, PhD, LAc, c/o Eric, Office Manager, 1800 Thayer Ave, Unit A, LA, CA 90025 310-474-2777. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: David Bresler, PhD, LAc, c/o Eric, Office Manager, 1800 Thayer Ave, Unit A, LA, CA 90025 310-474-2777. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If you have any questions regarding this notice or our health information privacy policies, please contact: David Bresler, PhD, LAc, c/o Eric, Office Manager, 1800 Thayer Ave, Unit A, LA, CA 90025 310-474-2777.

I have been informed of the Privacy Practices of The Bresler Center.

_____ _____ _____

Patient Name Patient Signature Date

THE BRESLER CENTER FOR MIND/BODY MEDICINE

INFORMED CONSENT TO ACUPUNCTURE TREATMENT

PLEASE READ THIS DOCUMENT CAREFULLY AND COMPLETELY. YOUR SIGNITURE ON THE LAST PAGE INDICATES THAT YOU HAVE READ THIS ENTIRE DOCUMENT, HAD YOUR QUESTIONS ANSWERED ABOUT THE ASSOCIATED RISKS AND EXPECTATIONS, AND CONSENTED TO RECEIVE TREATMENT.

Acupuncture treatment involves the superficial insertion of tiny, sterile, disposable acupuncture needles into the ear, face, scalp, neck and body in order to reduce pain, improve health, or enhance one's appearance. Treatment is customized for each individual and may utilize other modalities in conjunction with acupuncture if required for your care.

POTENTIAL RISKS OR COMPLICATIONS OF COSMETIC ACUPUNCTURE: Although most patients who receive acupuncture do not experience any adverse complications whatsoever, the potential side effects or risks that could occur are listed below:

A. BLEEDING AND BRUSING- When a needle is removed, some minor bleeding may occur. This is normal and usually will not leave a bruise. Occasionally, a bruise may appear. If so, it is important that you wear sunscreen when going outside. If bruising or swelling persists, call Dr. Bresler immediately.

B. INFECTION-Infection at the needle site following an acupuncture treatment is extremely rare because the needles are sterile and aseptic procedures are followed. If you suspect infection at the needling site (i.e. continued redness, swelling or warm to the touch), call Dr. Bresler immediately. Additional treatment or referral to your MD may be necessary.

C. DAMAGE TO DEEPER STRUCTURES- In theory, deeper structures such as blood vessels, nerves and muscles could potentially become temporarily or permanently damaged during the course of a Cosmetic Acupuncture treatment. This has never occurred in Dr. Bresler's practice in over 40 years.

D. NERVE INJURY-Injury to a motor or sensory nerve can potentially result from acupuncture treatments. Nerve injury could cause temporary or permanent numbness and/or loss of facial movements and feeling. Such injuries may improve over time, and painful nerve scarring is extremely rare.

E. NEEDLE SHOCK- Needle shock is a rare complication that can happen during any acupuncture treatment, especially if you have not eaten for many hours before treatment. If you feel faint or shaky at any time during the treatment, please let Dr. Bresler know immediately.

F. ALLERGIC REACTION-In extremely rare cases, local allergies to topical preparations have been reported. Though unlikely, systemic reactions that are more serious may occur to any herbs used in conjunction with acupuncture treatment.

G. DELAYED HEALING-Delayed healing is a very rare complication. Smoking and certain health conditions such as diabetes and chronic fatigue syndrome may delay the healing response of any of the aforementioned risks.

H. UNSATISFACTORY RESULTS- it is important to understand that not everyone is helped by acupuncture and results cannot be guaranteed.

DISCLAIMER: Informed consent documents are used to communicate information about the proposed procedure and to disclose all known risks and alternative forms of treatment. They are not intended to define or serve as the standard of acupuncture. However, informed consent documents should not be considered all-inclusive in defining other methods of care and potential risks. Standards of acupuncture are determined on the basis of all the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve. Dr. Bresler may provide you with additional or different information that is based on the facts in your particular case and the present state of knowledge within the field of acupuncture.

CONSENT AND SIGNATURE: My signature below indicates that I freely give my consent to receive acupuncture and related treatments at the Bresler Center. I do not expect Dr. Bresler to be able to anticipate and explain each and every potential risk and complication, and I prefer to rely on Dr. Bresler to exercise prudent judgment during the course of the procedure which he feels at the time is in my best interests, based on the facts then known. I understand how the treatment protocol involved will be undertaken, and Dr. Bresler has satisfactorily answered all my questions and addressed my expectations. I acknowledge that no guarantee has been given to me by anyone as to the results of treatment.

Patient's Name (Please print):_____ Date: _____

Patient Signature: _____

OUR FINANCIAL POLICY

Dr. Bresler and The Bresler Center staff are here to help in all aspects of your care, including financial arrangements. Our policy is that payment is made at the time services are rendered. Unless special arrangements are made in advance, and an additional service fee is paid, we will not bill your insurance company directly. This reduces our overhead expenses and helps keep our fees as low as possible.

We are open to discuss any special circumstances that affect your ability to pay for our services as they are rendered but special payment arrangements must be made prior to treatment with an agreement signed by both parties. There is a $15 service charge on all returned checks, a $15 per month service fee for direct billing your insurance company, and a 1.5% late charge per month (annual percentage rate =18%) on balances outstanding at the time of the next billing date.

ADVANCED NOTICE OF NON-COVERED SERVICES

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. **Medicare currently does not pay for acupuncture, guided imagery, and the other services we provide.** In accordance with the Medicare Act, Section 1842(i), we are therefore notifying you that Medicare is likely to deny payment for the services we render. Since Medicare will not pay for our services, you hereby agree to be personally and fully responsible for payment.

INSURANCE AUTHORIZATION

Dr. Bresler is licensed both as a psychologist and as an acupuncturist by the State of California. However, since he does not participate in any HMO or managed care organizations, many insurance companies do not provide full or even partial coverage for the services we provide. After each visit, we will provide you with forms needed to obtain reimbursement for services covered. You must contact your insurance company directly to determine the full extent of your insurance coverage.

MISSED APPOINTMENT POLICY

When you make an appointment, professional time is specially reserved to provide for your care. If you fail to appear for a scheduled appointment, or fail to give at least 24 hours notice prior to canceling your appointment, you will be charged in full for that appointment.

RECORD RELEASE AND AGREEMENT OF FINANCIAL RESPONSIBILITY

I authorize Dr. Bresler to provide copies of my medical records, billing statements, and other relevant information regarding my diagnosis and treatment to referring physicians, my insurance carrier(s) and/or my attorney. I agree that regardless of insurance or other coverage I may have, I am personally and directly responsible for all financial obligations incurred (unless my care has been authorized by a Workers

Date: _____ Signature: _____

10780 Santa Monica Blvd • Suite 290 • L os Angeles • CA 90025 •Phone 310-474-2777 • FAX 310-474-2771 • Email: Bresler@aol.com

THE BRESLER CENTER

PATIENT REGISTRATION FORM

Email:_____

PATIENT HISTORY

NAME _____ HEIGHT _____ WEIGHT _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP_____

TELEPHONE _____ DAY PHONE _____

SOCIAL SECURITY # _____ DRIVER LIC. # _____

AGE _____ BIRTHDATE _____ SEX _____ STATUS M S W D NO. CHILDREN _____

OCCUPATION _____ EMPLOYER _____ YEARS EMPLOYED _____

SPOUSE'S NAME _____ OCCUPATION _____ EMPLOYER _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ REFERRED BY _____

CLOSE RELATIVE OR FRIEND _____ ADDRESS _____ PHONE _____

SIGNIFICANT TRAVEL HISTORY _____

EXPOSURES (chemicals, radiation, paints, fumes, dusts, solvents, etc.) _____

PRIMARY HEALTH GOALS _____

IF PATIENT IS A MINOR, WHO IS PERSON RESPONSIBLE _____ SIGNATURE _____

MAIN REASONS FOR VISIT _____

KNOWN DIAGNOSES _____

FAMILY DOCTOR _____

OTHER DOCTORS INVOLVED IN YOUR CARE Name _____

Address _____

Phone _____

PAST MEDICAL HISTORY

SURGERY _____ BROKEN BONES _____

_____ BLOOD TRANSFUSIONS _____

ACCIDENTS _____ HOSPITALIZATIONS _____

ILLNESSES _____ HEAD INJURY _____

_____

TESTS AND IMMUNIZATIONS: Mark an **X** next to those which you have had. Enter the year when you last were given the test or "shots".

	YEAR		YEAR	**IMMUNIZATIONS**	YEAR
❑ chest x-ray	_____	❑ other x-rays	_____	❑ tetanus "shots"	_____
❑ kidney x-ray	_____	❑ TB test	_____	❑ flu injections	_____
❑ G.I. series	_____	❑ electrocardiogram	_____	❑ pneumovax	_____
❑ colon x-ray	_____	❑ MRI or CAT SCAN	_____	❑ other	_____
❑ back x-ray	_____	❑ Treadmill or stress EKG	_____		
Health Maintenance:					
❑ pap smear	_____	❑ rectal exam	_____	❑ cholesterol test	_____
❑ mammogram	_____	❑ stool blood test	_____	❑ blood tests	_____
❑ sigmoidoscopy	_____	❑ last general check-up	_____	❑ other	_____

[PRF 1.6]

HEALTH HABITS

List all vitamins, herbs, or medications you are presently taking (including dose and how often) _____

_____

Check yes or no and indicate how much and how often you use the following items. Circle day or week.

Tobacco smoking	☐ yes	☐ no	___ packs per day
Coffee	☐ yes	☐ no	___ cups per day/week
Tea	☐ yes	☐ no	___ cups per day/week
Alcohol	☐ yes	☐ no	___ drinks per day/week
Soft Drinks	☐ yes	☐ no	___ drinks per day/week
Artificial Sweetners	☐ yes	☐ no	___ packs per day/week

Glasses of water/fluid per day _____

Describe what you eat on a typical day or indicate what you ate yesterday and at what time you ate it. _____

_____

How many times a week do you eat in a restaurant? _____ Lunch _____ Dinner

What types of restaurants? _____

Favorite Foods _____

Do you crave sweets? _____ When? _____

Do you salt your food? _____ Before or after tasting? _____

Food Dislikes _____

Are you on any specific type of diet presently? _____

Do you feel good about your weight? _____

Would you like to decrease or increase your weight? _____

When did you last have a significant weight change? _____

What exercises/activities do you do and how often? _____

_____

How many hours of sleep do you get per night? _____ Is it restful? _____

Do you have adequate energy level? _____

Are you presently sexually active? _____ Any difficulties? _____

Current method of birth control _____

Mark an **X** on the line to indicate the stress level in your life 0 ——— 10

How much does the stress affect you 0 ——— 10

What are the major stresses in your life presently? _____

How many hours of free time do you have for yourself during weekdays? _____

During weekends? _____ Favorite pastime/recreational activity _____

Hobbies and Interests _____

_____

Have you ever been turned down for life insurance, military service, or employment because of health problems? _____

Are you pregnant? _____

ALLERGIES AND SENSITIVITIES

Is there a history of skin reaction or other untoward reaction or sickness following injection or oral administration of:

	Circle	Presently Taking	What Drug or Food?
Penicillin or other antibiotic	Yes	❑	_____
Morphine, Codeine, Demerol or other narcotics	Yes	❑	_____
Novocain or other anesthetics	Yes	❑	_____
Asprin, empirin or other pain remedies	Yes	❑	_____
Sulfa drugs	Yes	❑	_____
Tetanus antitoxin or other serums	Yes	❑	_____
Adhesive Tape	Yes	❑	_____
Iodine or methiolate	Yes	❑	_____
Any other drug or medication	Yes	❑	_____
Any foods, such as egg, milk or chocolate	Yes	❑	_____
Cortisone	Yes	❑	_____
Antiinflammatories	Yes	❑	_____
Anticoagulants	Yes	❑	_____
Tranquilizers	Yes	❑	_____
Hypotensives (high blood pressure medications)	Yes	❑	_____
Has the patient ever received treatment for:			
Asthma, rheumatism or rheumatic fever?	Yes	❑	_____
Antidepressants	Yes	❑	_____

FAMILY HISTORY

	HEALTH																								
	EXCELLENT	GOOD	FAIR	POOR	IF DECEASED CAUSE OF DEATH	ALLERGIES OR ASTHMA	ANEMIA	ARTHRITIS	BLEEDING TENDENCIES	CANCER OR TUMOR	DEPRESSION/MENTAL ILLNESS	DIABETES	EPILEPSY	GOUT	HEART DISEASE	HIGH BLOOD PRESSURE	IMMUNOLOGIC	KIDNEY OR BLADDER TROUBLE	STOMACH/DUODENAL ULCER	STROKE	TB	SYPHILIS,GONORRHEA	OTHER
FATHER																									
MOTHER																									
BROTHERS/SISTERS																									
SPOUSE																									
CHILDREN																									
GRANDPARENTS																									
OTHER BLOOD RELATIVES																									

Do you have or have you ever had the following?
If you check a box, please indicate N for new and P for past

GENERAL
- ❑ Fever, chills, sweats,fatigue
- ❑ Night sweats
- ❑ Fatigue
- ❑ Nervousness/anxiety
- ❑ Irritability
- ❑ Depression
- ❑ Generally feel "run down"
- ❑ Sexual abuse
- ❑ Emotional abuse
- ❑ Prolonged sadness/grief

SKIN
- ❑ Hives, rash
- ❑ Eczema, psoriasis
- ❑ Frequent infection or boils
- ❑ Abnormal pigmentations, moles
- ❑ Warts
- ❑ Herpes:
  - ❑ lips
  - ❑ genital
  - ❑ zoster

NECK
- ❑ Injury/Pain
- ❑ Neck pain with movement
  - ❑ forward
  - ❑ backward
  - ❑ turn to left
  - ❑ turn to right
  - ❑ bend to left
  - ❑ bend to right
- ❑ Pinched nerve in neck
- ❑ Neck feels out of place
- ❑ Muscle spasms in neck
- ❑ Grinding sounds in neck
- ❑ Popping sounds in neck
- ❑ Arthritis in neck
- ❑ Swollen glands

HEAD-EYES-EARS-NOSE-THROAT
- ❑ Headache
  - ❑ sinus (allergy)
  - ❑ tension
  - ❑ migraine
- ❑ Head feels "heavy"
- ❑ Loss of memory
- ❑ Lightheadedness
- ❑ Light bothers eyes
- ❑ Loss of balance
- ❑ Dizziness
- ❑ Loss of hearing
- ❑ Ear disease
- ❑ Eye disease or injury
- ❑ Blurry vision
- ❑ Double vision
- ❑ Loss of vision
- ❑ Glaucoma, cataracts
- ❑ Runny nose
- ❑ Nosebleeds
- ❑ Chronic sinus trouble
- ❑ Snoring
- ❑ Impaired hearing
- ❑ Ringing in ears
- ❑ Buzzing in ears
- ❑ Vertigo
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Tooth & gum problems
- ❑ Loss of taste

RESPIRATORY
- ❑ Frequent "colds"
- ❑ Difficulty breathing
- ❑ Chronic or frequent cough
- ❑ Asthma or wheezing
- ❑ Emphysema
- ❑ Spitting up blood
- ❑ Pleurisy
- ❑ Pneumonia

CARDIOVASCULAR
- ❑ High blood pressure
- ❑ Palpitation, irregular heart beat
- ❑ Rheumatic fever
- ❑ Chest pain or angina
- ❑ Shortness of breath with walking or lying down
- ❑ Difficulty walking two blocks
- ❑ Heart trouble or heart attacks
- ❑ Heart murmur
- ❑ Awakening in the night smothering
- ❑ Swelling of hands, feet, or ankles
- ❑ Need more than one pillow to sleep
- ❑ Claudication/pain in calves with walking, relieved by rest

HEMATOLOGIC
- ❑ Anemia
- ❑ Phlebitis/ blood clots
- ❑ Are you slow to heal after cuts or bruising
- ❑ Difficulty with bleeding excessively after tooth extraction or surgery
- ❑ Excessive bleeding/ bruising
- ❑ Mononucleosis

GASTROINTESTINAL
- ❑ Food sticks in throat/ difficulty swallowing
- ❑ Vomiting blood or food
- ❑ Ulcer (stomach or duodenal)
- ❑ Gallbladder disease
- ❑ Liver trouble/hepatitis
- ❑ Diarrhea
- ❑ Constipation
- ❑ "Nervous" stomach
- ❑ Nausea and/or vomiting
- ❑ Gas

GENITOURINARY
- ❑ Loss of urine
- ❑ Frequent urination
- ❑ Burning or painful urination
- ❑ Blood in urine
- ❑ Kidney trouble
- ❑ Straining to urinate
- ❑ Hernia
- ❑ Venereal disease

GYNECOLOGICAL

- ❑ Age periods started _____
- ❑ Duration of periods _____ days
- ❑ Frequency of periods, every ___ days
- ❑ Menstrual pain
- ❑ Cramping
- ❑ Irregularity
- ❑ Number of pregnancies _____
- ❑ Number of children _____
- ❑ Number of miscarriages _____
- ❑ Abortions
- ❑ Hysterectomy
- ❑ Discharge _____ color
- ❑ Tumors
- ❑ Date of menopause _____
- ❑ Hot flashes
- ❑ Menopausal bleeding
- ❑ Breast pain
- ❑ Breast lumps
- ❑ Nipple discharge or bleeding

MEN ONLY

- ❑ Urinary frequency
- ❑ Difficulty in starting
- ❑ Night urination
- ❑ Prostate pain/swelling

LOCOMOTOR-MUSCULOSKELETAL

- ❑ Arthritis or joint pain
- ❑ Weakness of muscles or joints
- ❑ Back pain
- ❑ Difficulty walking

NEUROPSYCHIATRIC

- ❑ Headaches
- ❑ Fainting spells
- ❑ Epilepsy
- ❑ Stroke
- ❑ Paralysis

ENDOCRINE

- ❑ Thyroid disease
- ❑ Heat or cold intolerance
- ❑ Dry Skin
- ❑ Change in hair growth or texture
- ❑ Excessive thirst or urination
- ❑ Sexual problems
- ❑ Hormone therapy
- ❑ Low or high sex drive

THERAPEUTIC TECHNIQUES

- ❑ Acupuncture
- ❑ Herbal Medicine
- ❑ Homeopathy
- ❑ Bach Flowers
- ❑ Hellerwork
- ❑ Rolfing
- ❑ Massage
- ❑ Chiropractic
- ❑ Psychotherapy
- ❑ Visualization
- ❑ Guided Imagery
- ❑ Biofeedback
- ❑ Feldenkreis
- ❑ Reiki
- ❑ Polarity
- ❑ Tragerwork
- ❑ Craniosacral Therapy
- ❑ Other _____

SHOULDERS

- ❑ Pain in shoulder joint (R/L)
- ❑ Pain across shoulders
- ❑ Bursitis (R/L)
- ❑ Arthritis (R/L)
- ❑ Can't raise arm
  - ❑ above shoulder level
  - ❑ over head
- ❑ Tension in shoulders
- ❑ Pinched nerve in shoulder (R/L)
- ❑ Muscle spasms in shoulders

ARMS AND HANDS

- ❑ Pain in upper arm
- ❑ Pain in elbow
- ❑ Movement aggravated
- ❑ Tennis elbow
- ❑ Pain in forearm
- ❑ Pain in hands
- ❑ Pain in fingers
- ❑ Sensation of pins & needles in arms
- ❑ Sensation of pins & needles in fingers
- ❑ Numbness in arms (R/L)
- ❑ Numbness in fingers (R/L)
- ❑ Fingers go to sleep
- ❑ Hands cold
- ❑ Swollen joints in fingers
- ❑ Sore joints in fingers
- ❑ Arthritis in fingers
- ❑ Loss of grip strength

MID-BACK

- ❑ Mid-back pain
- ❑ Location
- ❑ Pain between shoulder blades
- ❑ Sharp stabbing
- ❑ Dull ache
- ❑ Pain from front to back
- ❑ Muscle spasms
- ❑ Pain in kidney area

CHEST

- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Pain around ribs
- ❑ Dimpled or orange peel breast

LOW BACK

- ❑ Low back pain
  - ❑ upper lumbar
  - ❑ lower lumbar
  - ❑ Sacroiliac
- ❑ Low back pain is worse when
  - ❑ working
  - ❑ lifting
  - ❑ stooping
  - ❑ standing
  - ❑ sitting
  - ❑ bending
  - ❑ coughing
  - ❑ lying down (sleeping)
  - ❑ walking
  - ❑ other _____
- ❑ Pain relieved with
  - ❑ ice, heat
  - ❑ movement
  - ❑ physical therapy
  - ❑ topical analgesics
  - ❑ medications
  - ❑ other _____
- ❑ Slipped disk
- ❑ Low back feels out of place
- ❑ Muscle spasms

HIPS, LEGS AND FEET

- ❑ Pain in buttocks (R/L)
- ❑ Pain in hip joint (R/L)
- ❑ Pain down leg (R/L)
- ❑ Pain down both legs
- ❑ Knee pain
- ❑ Leg cramps
- ❑ Cramps in feet (R/L)
- ❑ Pins & needles in legs (R/L)
- ❑ Numbness of leg (R/L)
- ❑ Numbness of feet (R/L)
- ❑ Numbness of toes
- ❑ Feet feel cold
- ❑ Swollen ankles (R/L)
- ❑ Swollen feet (R/L)

In the drawing on the right, please shade the areas of the body where you experience pain and use arrows to show how and where the pain radiates.