Select affected body part(s) from list below:

|  |
| --- |
| **FRONT of BODY** |
| [ ]  **Left Side of Body** | [ ]  **Right Side of Body** |
|[ ]  HEAD |
|[ ]  EYE |
|[ ]  EAR |
|[ ]  NOSE |
|[ ]  FACE |
|[ ]  JAW |
|[ ]  FOREHEAD |
|[ ]  EYEBROW |
|[ ]  CHEEK |
|[ ]  MOUTH |
|[ ]  CHIN |
|[ ]  SHOULDER |
|[ ]  ARMPIT |
|[ ]  CHEST |
|[ ]  FOREARM |
|[ ]  WRIST |
|[ ]  ABDOMEN |
|[ ]  HAND |
|[ ]  THUMB |
|[ ]  INDEX FINGER |
|[ ]  MIDDLE FINGER |
|[ ]  RING FINGER |
|[ ]  LITTLE FINGER |
|[ ]  HIP |
|[ ]  THIGH  |
|[ ]  KNEE  |
|[ ]  LOWER LEG  |
|[ ]  ANKLE  |
|[ ]  FOOT  |
|[ ]  TOE(s) |

