Name: _____ Birth Date: _____ Today's Date: _____

Do you have any of the following symptoms? Fill in bubble Yes or No

Joint pain	○ Yes	○ No
Joint stiffness	○ Yes	◉ No
Weight gain	○ Yes	○ No
Loss of appetite	○ Yes	○ No
Fever	○ Yes	○ No
Weakness	○ Yes	○ No
Weight loss	○ Yes	○ No
Headache	○ Yes	○ No
Weakness in arms	○ Yes	○ No
Weakness in legs	○ Yes	○ No
Tingling or numbness	○ Yes	○ No
Bowel or bladder incontinence	○ Yes	○ No
Trouble sleeping	○ Yes	○ No
Nausea/Vomiting	○ Yes	○ No
Itching, rash	○ Yes	○ No
Constipation	○ Yes	○ No
Sedation	○ Yes	○ No
Fatigue	○ Yes	○ No
Chest pain	○ Yes	○ No
Shortness of breath	○ Yes	○ No
High stress level	○ Yes	○ No
Are you receiving counseling	○ Yes	○ No
Diarrhea	○ Yes	○ No
Abdominal pain	○ Yes	○ No