

SYMPTOM SURVEY FORM (*Maestro*)



Patient		Doctor		Date	
Birth Date:		Approx. Weight		Sex: Male <input type="checkbox"/>	Female <input type="checkbox"/>
Pulse: Recumbent		Standing:		Vegetarian: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Blood Pressure: Recumbent:		/	Standing:		/
					Ragland's Test is Positive <input type="checkbox"/>

INSTRUCTIONS: Fill in only the boxes which apply to you.

MILD (occurred once or twice last 6 months)

MODERATE (occurred once or twice last month)

SEVERE (chronic, occurred once or twice last week)

Leave **BLANK** if they don't apply to you

- | | 1 | 2 | 3 | |
|----|--------------------------|--------------------------|--------------------------|--|
| | | | | GROUP 1 |
| 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acid foods upset |
| 2 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Get chilled often |
| 3 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | "Lump" in throat |
| 4 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dry mouth-eyes-nose |
| 5 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pulse speeds after meal |
| 6 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Keyed up – fail to calm |
| 7 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cut heals slowly |
| 8 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gag easily |
| 9 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Unable to relax: startles easily |
| 10 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Extremities cold, clammy |
| 11 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strong light irritates |
| 12 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Urine amount reduced |
| 13 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart pounds after retiring |
| 14 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | "Nervous" stomach |
| 15 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Appetite reduced |
| 16 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cold sweats often |
| 17 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fever easily raised |
| 18 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neuralgia-like pains |
| 19 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Staring, blinks little |
| 20 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sour stomach often |
| | | | | GROUP 2 |
| 21 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Joint stiffness or arising |
| 22 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle-leg-toe cramps at night |
| 23 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | "Butterfly" stomach, cramps |
| 24 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eyes or nose watery |
| 25 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eyes blink often |
| 26 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eyelids swollen, puffy |
| 27 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Indigestion soon after meals |
| 28 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Always seems hungry; feels lightheaded often |
| 29 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Digestion rapid |

- | | | | | |
|----|--------------------------|--------------------------|--------------------------|---|
| 30 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting frequent |
| 31 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hoarseness frequent |
| 32 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Breathing irregular |
| 33 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pulse slow, feels irregular |
| 34 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gagging reflex slow |
| 35 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing |
| 36 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation, diarrhea alternating |
| 37 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | "Slow starter" |
| 38 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Get "chilled" infrequently |
| 39 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perspire easily |
| 40 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Circulation poor, sensitive to cold |
| 41 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Subject to colds, asthma, bronchitis |
| | | | | GROUP 3 |
| 42 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat when nervous |
| 43 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive appetite |
| 44 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hungry between meals |
| 45 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritable before meals |
| 46 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Get "shaky" if hungry |
| 47 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fatigue, eating relieves |
| 48 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | "Lightheaded" if meals delayed |
| 49 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart palpitates if meals missed or delayed |
| 50 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Afternoon headaches |
| 51 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Overeating sweets upsets |
| 52 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Awaken after a few hours' sleep – hard to get back to sleep |
| 53 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Crave candy or coffee in afternoons |
| 54 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Moods of depression – "blues" or melancholy |
| 55 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal craving for sweets or snacks |

- | | 1 | 2 | 3 | GROUP 4 |
|----|--------------------------|--------------------------|--------------------------|---|
| 56 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hands & feet go to sleep easily, numbness |
| 57 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sigh frequently, "air hunger" |
| 58 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Aware of "breathing heavily" |
| 59 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High altitude discomfort |
| 60 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Opens windows in closed rooms |
| 61 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Susceptible to colds and fevers |
| 62 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Afternoon "yawner" |
| 63 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Get "drowsy" often |
| 64 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swollen ankles, worse at night |
| 65 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle cramps, worse during exercise; get "charley horses" |
| 66 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath on exertion |
| 67 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dull pain in chest or radiating into left arm, worse on exertion |
| 68 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bruise easily, "black and blue" spots |
| 69 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tendency to anemia |
| 70 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | "Nose bleeds" frequently |
| 71 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tension under breastbone, or feeling of "lightness" worse on exertion |

- | | 1 | 2 | 3 | GROUP 5 |
|----|--------------------------|--------------------------|--------------------------|--|
| 73 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| 74 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dry Skin |
| 75 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Burning feet |
| 76 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision |
| 77 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Itching skin and feet |
| 78 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive falling hair |
| 79 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent skin rashes |
| 80 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bitter, metallic taste in mouth in mornings |
| 81 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bowel movements painful or difficult |
| 82 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Worrier, feels insecure |
| 83 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feeling queasy; headache over eyes |
| 84 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Greasy feeds upset |
| 85 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stools light colored |
| 86 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin peels on foot soles |
| 87 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain between shoulder blades |
| 88 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Use Laxatives |
| 89 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stools alternate from soft to watery |
| 90 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History of gallbladder attacks or gallstones |
| 91 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sneezing attacks |
| 92 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dreaming, nightmare type bad dreams |
| 93 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bad breath (halitosis) |
| 94 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Milk products cause distress |
| 95 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sensitive to hot weather |
| 96 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Burning or itching anus |
| 97 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Crave Sweets |

- | | 1 | 2 | 3 | GROUP 6 |
|-----|--------------------------|--------------------------|--------------------------|---|
| 98 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of taste for meat |
| 99 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lower bowel gas several hours after eating |
| 100 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Burning stomach sensations, eating relieves |
| 101 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Coated tongue |
| 102 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pass large amounts of foul-smelling gas |
| 103 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Indigestion ½ - 1 hour after eating; may be up to 3-4 hours |
| 104 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mucous colitis or "irritable bowel" |
| 105 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gas shortly after eating |
| 106 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stomach "bloating" after eating |

- | | 1 | 2 | 3 | GROUP 7A |
|-----|--------------------------|--------------------------|--------------------------|--|
| 107 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insomnia |
| 108 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervousness |
| 109 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Can't gain weight |
| 110 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Intolerance to heat |
| 111 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Highly emotional |
| 112 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Flush easily |
| 113 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Night sweats |
| 114 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thin, moist skin |
| 115 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inward trembling |
| 116 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart palpitates |
| 117 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Increased appetite without weight gain |
| 118 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pulse fast at rest |
| 119 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eyelids and face twitch |
| 120 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritable and restless |
| 121 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Can't work under pressure |

- | | 1 | 2 | 3 | GROUP 7B |
|-----|--------------------------|--------------------------|--------------------------|---|
| 122 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Increase in weight |
| 123 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Decrease in appetite |
| 124 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fatigue easily |
| 125 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ringing in ears |
| 126 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sleepy during day |
| 127 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sensitive to cold |
| 128 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dry or scaly skin |
| 129 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| 130 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mental sluggishness |
| 131 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hair coarse, falls out |
| 132 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headaches upon arising, wear off during day |
| 133 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Slow pulse, below 65 |
| 134 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequency of urination |
| 135 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Impaired hearing |
| 136 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Reduced initiative |

- | | 1 | 2 | 3 | GROUP 7C |
|-----|--------------------------|--------------------------|--------------------------|--|
| 137 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Failing memory |
| 138 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure |
| 139 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Increased sex drive |
| 140 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headaches, "splitting or rending" type |
| 141 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Decreased sugar tolerance |

- | | 1 | 2 | 3 | GROUP 7D |
|-----|--------------------------|--------------------------|--------------------------|---|
| 142 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal thirst |
| 143 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bloating of abdomen |
| 144 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Weight gain around hips or waist |
| 145 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sex drive reduced or lacking |
| 146 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tendency to ulcers, colitis |
| 147 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Increased sugar tolerance |
| 148 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Women: menstrual disorders |
| 149 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Young girls: lack of menstrual function |

- | | 1 | 2 | 3 | GROUP 7E |
|-----|--------------------------|--------------------------|--------------------------|--------------------------------------|
| 150 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| 151 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| 152 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hot flashes |
| 153 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Increased blood pressure |
| 154 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hair growth on face or body (female) |
| 155 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sugar in urine (not diabetes) |
| 156 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Masculine tendencies (female) |

- | | 1 | 2 | 3 | GROUP 7F |
|-----|--------------------------|--------------------------|--------------------------|-----------------------------------|
| 157 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Weakness, dizziness |
| 158 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic fatigue |
| 159 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure |
| 160 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nails weak, ridged |
| 161 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tendency to hives |
| 162 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritic tendencies |
| 163 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perspiration increase |
| 164 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bowel disorders |
| 165 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor circulation |
| 166 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swollen ankles |
| 167 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Crave salt |
| 168 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Brown spots or bronzing of skin |
| 169 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergies – tendency to asthma |
| 170 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Weakness after colds, influenza |
| 171 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Exhaustion – muscular and nervous |
| 172 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory disorders |

- | | 1 | 2 | 3 | GROUP 8 |
|-----|--------------------------|--------------------------|--------------------------|--|
| 173 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Apprehension |
| 174 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritability |
| 175 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Morbid fears |
| 176 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Never seems to get well |
| 177 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Forgetfulness |
| 178 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Indigestion |
| 179 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor appetite |
| 180 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Craving for sweets |
| 181 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscular soreness |
| 182 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression; feeling of dread |
| 183 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Noise sensitivity |
| 184 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acoustic Hallucinations |
| 185 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tendency to cry without reason |
| 186 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hair is coarse and/or thinning |
| 187 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Weakness |
| 188 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fatigue |
| 189 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin Sensitive to touch |
| 190 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tendency toward hives |
| 191 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervousness |
| 192 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headache |
| 193 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insomnia |
| 194 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |
| 195 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anorexia |
| 196 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inability to concentrate; confusion |
| 197 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent stuffy nose; sinus infections |
| 198 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergy to some foods |
| 199 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loose joints |

- | | 1 | 2 | 3 | FEMALE ONLY |
|-----|--------------------------|--------------------------|--------------------------|--|
| 200 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Very easily fatigued |
| 201 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Premenstrual tension |
| 202 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful menses |
| 203 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depressed feelings before menstruation |
| 204 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Menstruation excessive and prolonged |
| 205 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful breasts |
| 206 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Menstruate too frequently |
| 207 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vaginal discharge |
| 208 | | | <input type="checkbox"/> | Hysterectomy / ovaries removed |
| 209 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Menopausal hot flashes |
| 210 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Menses scanty or missing |
| 211 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acne, worse at menses |
| 212 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression of long standing |

	1	2	3	MALE ONLY
213	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate trouble
214	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urination difficult or dribbling
215	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night urination frequent
216	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression
217	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain on inside of legs or heels
218	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling of incomplete bowel evacuation
219	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of energy
220	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migration aches and pains
221	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tire too easily
222	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoids activity
223	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legs nervousness at night
224	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diminished sex drive

List the five main complaints you have in the order of their importance:

1.

2.

3.

4.

5.