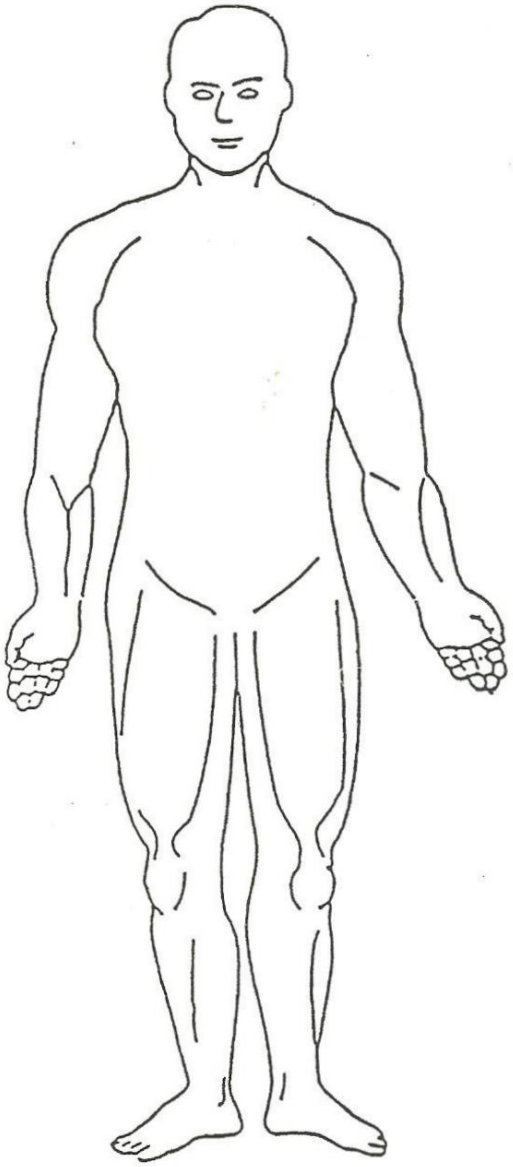
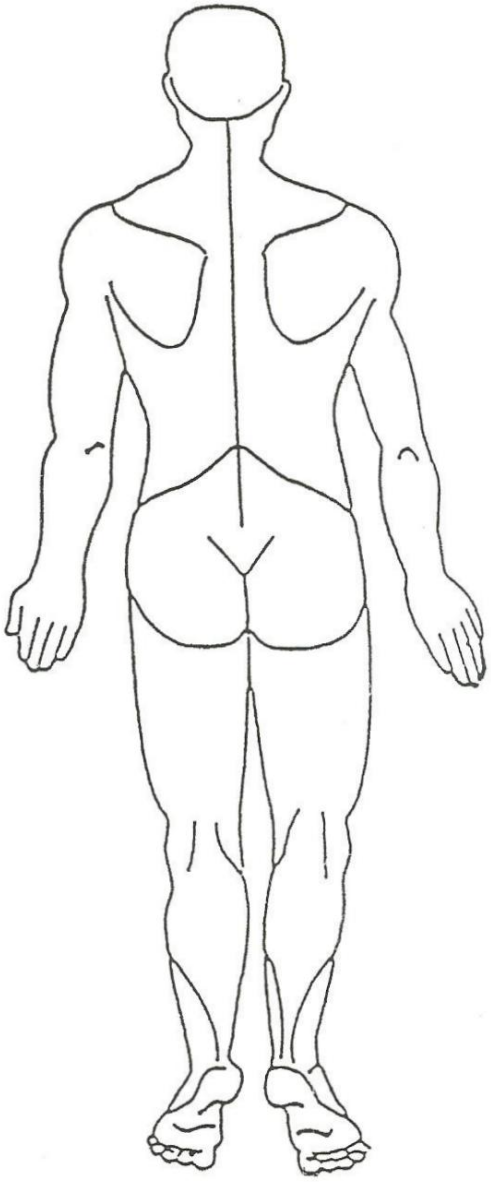
PATIENT: _____ DATE: _____





	FATIGUE		HUNGER TREMORS		EYE IRRITATION		BLOATING		ITCHING
	IRRITABILITY		PALPITATIONS		NASAL CONGESTION		CONSTIPATION		RASHES
	NERVOUSNESS		PANIC ATTACKS		ABNORMAL TASTES		DIARRHEA		SENSITIVITIES
	DEPRESSION		FRONTAL HEADACHES		a) BAD		DYSURIA		a) CHEMICAL
	INSOMNIA		OCCIPITAL HEADACHES		b) METALLIC		PUNGENT URINE		b) LIGHT
	IMPAIRED CONCENTRATION		GENERAL HEADACHES		RINGING EARS		BLADDER INFECTIONS		c) SOUNDS
	IMPAIRED MEMORY		DIZZINESS		NUMBNESS		VULVODYNIA		d) ODOR
	ANXIETY		a) VERTIGO		RESTLESS LEGS		WEIGHT CHANGES		ALLERGIES
	SALT CRAVING		b) IMBALANCE		LEG CRAMPS		BRITTLE NAILS		GROWING PAINS
	SUGAR CRAVING		c) FAINTNESS		NAUSEA		BRUISING		PAIN
	SWEATING		BLURRED VISION		GAS		SKIN SENSATIONS		