Brief COPE (PTLDS)

These items deal with *ways you've been coping with stress in your life, specifically any problems associated with your overall health in the past several months. If you have not had any health problems in the last several months, then rate the items based on how you have been coping with any stress in your life, across the past several months.* There are many ways to try to deal with problems. These items ask what you've been doing to cope with these problems. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it.

Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently. Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

1 = I haven't been doing this at all
2 = I've been doing this a little bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

I am answering these questions based on (please check one): ☐ Overall health problems ☐ Other, non-health stressors

1. I've been turning to work or other activities to take my mind off things. **1 2 3 4**
2. I've been concentrating my efforts on doing something about the situation I'm in. **1 2 3 4**
3. I've been saying to myself "this isn't real." **1 2 3 4**
4. I've been using alcohol or other drugs to make myself feel better. **1 2 3 4**
5. I've been getting emotional support from others. **1 2 3 4**
6. I've been giving up trying to deal with it. **1 2 3 4**
7. I've been taking action to try to make the situation better. **1 2 3 4**
8. I've been refusing to believe that it has happened. **1 2 3 4**
9. I've been saying things to let my unpleasant feelings escape. **1 2 3 4**
10. I've been getting help and advice from other people. **1 2 3 4**
11. I've been using alcohol or other drugs to help me get through it. **1 2 3 4**

12. I've been trying to see it in a different light, to make it seem more positive.	1 2 3 4
13. I've been criticizing myself.	1 2 3 4
14. I've been trying to come up with a strategy about what to do.	1 2 3 4
15. I've been getting comfort and understanding from someone.	1 2 3 4
16. I've been giving up the attempt to cope.	1 2 3 4
17. I've been looking for something good in what is happening.	1 2 3 4
18. I've been making jokes about it.	1 2 3 4
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.	1 2 3 4
20. I've been accepting the reality of the fact that it has happened.	1 2 3 4
21. I've been expressing my negative feelings.	1 2 3 4
22. I've been trying to find comfort in my religion or spiritual beliefs.	1 2 3 4
23. I've been trying to get advice or help from other people about what to do.	1 2 3 4
24. I've been learning to live with it.	1 2 3 4
25. I've been thinking hard about what steps to take.	1 2 3 4
26. I've been blaming myself for things that happened.	1 2 3 4
27. I've been praying or meditating.	1 2 3 4
28. I've been making fun of the situation.	1 2 3 4

SF-36 - This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. *Thank you for completing this survey!*

For each of the following questions, please mark an 'X' in the one box that best describes your answer.

1. In general, would you say your health is:

Excellent	Very Good	Good	Fair	Poor
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

2. Compared to one year ago, how would you rate your health in general now?

Much better now than one year ago	Somewhat better now than one year ago	About the same as one year ago	Somewhat worse now than one year ago	Much worse now than one year ago
☐	☐	☐	☐	☐

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot (1)	Yes, limited a little (2)	No, not limited at all (3)
a Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	☐	☐	☐
b Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
c Lifting or carrying groceries	☐	☐	☐
d Climbing several flights of stairs	☐	☐	☐
e Climbing one flight of stairs	☐	☐	☐
f Bending, kneeling, or stooping	☐	☐	☐
g Walking more than a mile	☐	☐	☐
h Walking several hundred yards	☐	☐	☐
i Walking one hundred yards	☐	☐	☐
l Bathing or dressing yourself	☐	☐	☐

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time (1)	Most of the time (2)	Some of the time (3)	A little of the time (4)	None of the time (5)
Cut down on the amount of time you spent on work or other activities	☐	☐	☐	☐	☐
Accomplished less than you would like	☐	☐	☐	☐	☐
Were limited in the kind of work or other activities	☐	☐	☐	☐	☐
Had difficulty performing the work or other activities (for example, it took extra effort)	☐	☐	☐	☐	☐

5. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time (1)	Most of the time (2)	Some of the time (3)	A little of the time (4)	None of the time (5)
Cut down on the amount of time you spent on work or other activities	☐	☐	☐	☐	☐
Accomplished less than you would like	☐	☐	☐	☐	☐
Did work or other activities less carefully than usual	☐	☐	☐	☐	☐

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all	Slightly	Moderately	Quite a bit	Extremely
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7. How much bodily pain have you had during the past 4 weeks?

None	Very mild	Mild	Moderate	Severe	Very severe
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
☐	☐	☐	☐	☐

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks…

	All of the time (1)	Most of the time (2)	Some of the time (3)	A little of the time (4)	None of the time (5)
Did you feel full of life?	☐	☐	☐	☐	☐
Have you been very nervous?	☐	☐	☐	☐	☐
Have you felt so down in the dumps that nothing could cheer you up?	☐	☐	☐	☐	☐
Have you felt calm and peaceful?	☐	☐	☐	☐	☐
Did you have a lot of energy?	☐	☐	☐	☐	☐
Have you felt downhearted and depressed?	☐	☐	☐	☐	☐
Did you feel worn out?	☐	☐	☐	☐	☐
Have you been happy?	☐	☐	☐	☐	☐
Did you feel tired?	☐	☐	☐	☐	☐

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

11. How TRUE or FALSE is each of the following statements for you?

	Definitely true (1)	Mostly true (2)	Don't know (3)	Mostly false (4)	Definitely false (5)
I seem to get sick a little easier than other people	☐	☐	☐	☐	☐
I am as healthy as anybody I know	☐	☐	☐	☐	☐
I expect my health to get worse	☐	☐	☐	☐	☐
My health is excellent	☐	☐	☐	☐	☐

Beck Inventory

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness 0 I do not feel sad. 1 I feel sad much of the time. 2 I am sad all the time. 3 I am so sad or unhappy that I can't stand it.	**6. Punishment Feelings** 0 I don't feel I am being punished. 1 I feel I may be punished. 2 I expect to be punished. 3 I feel I am being punished.
2. Pessimism 0 I am not discouraged about my future. 1 I feel more discouraged about my future than I used to be. 2 I do not expect things to work out for me. 3 I feel my future is hopeless and will only get worse.	**7. Self-Dislike** 0 I feel the same about myself as ever. 1 I have lost confidence in myself. 2 I am disappointed in myself. 3 I dislike myself.
3. Past Failure 0 I do not feel like a failure. 1 I have failed more than I should have. 2 As I look back, I see a lot of failures. 3 I feel I am a total failure as a person.	**8. Self-Criticalness** 0 I don't criticize or blame myself more than usual. 1 I am more critical of myself than I used to be. 2 I criticize myself for all of my faults. 3 I blame myself for everything bad that happens.
4. Loss of Pleasure 0 I get as much pleasure as I ever did from the things I enjoy. 1 I don't enjoy things as much as I used to. 2 I get very little pleasure from the things I used to enjoy. 3 I can't get any pleasure from the things I used to enjoy.	**9. Suicidal Thoughts or Wishes** 0 I don't have any thoughts of killing myself. 1 I have thoughts of killing myself, but I would not carry them out. 2 I would like to kill myself. 3 I would kill myself if I had the chance.
5. Guilty Feelings 0 I don't feel particularly guilty. 1 I feel guilty over many things I have done or should have done. 2 I feel quite guilty most of the time. 3 I feel guilty all of the time.	**10. Crying** 0 I don't cry any more than I used to. 1 I cry more than I used to. 2 I cry over every little thing. 3 I feel like crying, but I can't.

11. Agitation 0 I am no more restless or wound up than usual. 1 I feel more restless or wound up than usual. 2 I am so restless or agitated that it's hard to stay still. 3 I am so restless or agitated that I have to keep moving or doing something.	**17. Irritability** 0 I am no more irritable than usual. 1 I am more irritable than usual. 2 I am much more irritable than usual. 3 I am irritable all the time.
12. Loss of Interest 0 I have not lost interest in other people or activities. 1 I am less interested in other people or things than before. 2 I have lost most of my interest in other people or things. 3 It's hard to get interested in anything.	**18. Changes in Appetite** 0 I have no experienced any change in my appetite. 1a My appetite is somewhat less than usual. 1b My appetite is somewhat more than usual. 2a My appetite is much less than before. 2b My appetite is much more than before. 3a I have no appetite at all. 3b I crave food all the time.
13. Indecisiveness 0 I make decisions about as well as ever. 1 I find it more difficult to make decisions than usual. 2 I have much greater difficulty in making decisions than I used to. 3 I have trouble making any decisions.	**19. Concentration Difficulty** 0 I can concentrate as well as ever. 1 I can't concentrate as well as usual. 2 It's hard to keep my mind on anything for very long. 3 I find I can't concentrate on anything.
14. Worthlessness 0 I do not feel I am worthless. 1 I don't consider myself as worthwhile and useful as I used to. 2 I feel more worthless as compared to other people. 3 I feel utterly worthless.	**20. Tiredness or Fatigue** 0 I am no more tired or fatigued than usual. 1 I get more tired or fatigued more easily than usual. 2 I am too tired or fatigued to do a lot of the things I used to do. 3 I am too tired or fatigued to do most of the things I used to do.
15. Loss of Energy 0 I have as much energy as ever. 1 I have less energy than I used to have. 2 I don't have enough energy to do very much. 3 I don't have enough energy to do anything.	**21. Loss of Interest in Sex** 0 I have not noticed any recent change in my interest in sex. 1 I am less interested in sex than I used to be. 2 I am much less interested in sex now. 3 I have lost interest in sex completely.
16. Changes in Sleeping Pattern 0 I have not experienced any change in my sleeping pattern. 1a I sleep somewhat more than usual. 1b I sleep somewhat less than usual. 2a I sleep a lot more than usual. 2b I sleep a lot less than usual. 3a I sleep most of the day. 3b I wake up 1-2 hours early and can't get back to sleep.	

Fatigue Severity Scale

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.
- It is important that you circle a number (1 to 7) for every question.

During the past week, I have found that:	Disagree ←----→ Agree						
1. My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
3. I am easily fatigued.	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
8. Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7

Short-Form McGill Pain Questionnaire

PLEASE SELECT FROM THE LIST BELOW WORDS THAT YOU WOULD USE TO DESCRIBE YOUR PAIN (tick the appropriate box in each column for each word).

	NONE (0)	MILD (1)	MODERATE (2)	SEVERE (3)
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot-burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-exhausting				
Sickening				
Fearful				
Punishing-cruel				

MARK A CROSS ON THE LINE BELOW TO INDICATE THE INTENSITY OF YOUR PAIN:

(a) Right now: *No pain* ——— *Worst possible pain*

(b) At its worst in the last month: *No pain* ——— *Worst possible pain*

(c) At its best in the last month: *No pain* ——— *Worst possible pain*

WHICH OF THE FOLLOWING WORDS EXPLAINS YOUR PRESENT PAIN (tick only one):

- ☐ No pain
- ☐ Mild pain
- ☐ Discomforting
- ☐ Distressing
- ☐ Horrible
- ☐ Excruciating

The Big Five Inventory (BFI)

Here are a number of characteristics that may or may not apply to you. For example, do you agree that you are someone who likes to spend time with others? Please write a number next to each statement to indicate the extent to which you agree or disagree with that statement.

Disagree strongly	Disagree a little	Neither agree nor disagree	Agree a little	Agree Strongly
1	**2**	**3**	**4**	**5**

I see myself as someone who...

____1. Is talkative

____2. Tends to find fault with others

____3. Does a thorough job

____4. Is depressed, blue

____5. Is original, comes up with new ideas

____6. Is reserved

____7. Is helpful and unselfish with others

____8. Can be somewhat careless

____9. Is relaxed, handles stress well

____10. Is curious about many different things

____11. Is full of energy

____12. Starts quarrels with others

____13. Is a reliable worker

____14. Can be tense

____15. Is ingenious, a deep thinker

____16. Generates a lot of enthusiasm

____17. Has a forgiving nature

____18. Tends to be disorganized

____19. Worries a lot

____20. Has an active imagination

____21. Tends to be quiet

____22. Is generally trusting

____23. Tends to be lazy

____24. Is emotionally stable, not easily upset

____25. Is inventive

____26. Has an assertive personality

____27. Can be cold and aloof

____28. Perseveres until the task is finished

____29. Can be moody

____30. Values artistic, aesthetic experiences

____31. Is sometimes shy, inhibited

____32. Is considerate and kind to almost everyone

____33. Does things efficiently

____34. Remains calm in tense situations

____35. Prefers work that is routine

____36. Is outgoing, sociable

____37. Is sometimes rude to others

____38. Makes plans and follows through with them

____39. Gets nervous easily

____40. Likes to reflect, play with ideas

____41. Has few artistic interests

____42. Likes to cooperate with others

____43. Is easily distracted

____44. Is sophisticated in art, music, or literature

Fibromyalgia Assessment Questionnaire (FAQ)

Pain Location Inventory

1. For each of the following, please indicate if you have had pain or tenderness over the past week:

☐ Left shoulder	☐ Left hip	☐ Left jaw
☐ Right shoulder	☐ Right hip	☐ Right jaw
☐ Left upper arm	☐ Left upper leg	☐ Lower back
☐ Right upper arm	☐ Right upper leg	☐ Upper back
☐ Left lower arm	☐ Left lower leg	☐ Chest
☐ Right lower arm	☐ Right lower leg	☐ Abdomen
		☐ Neck

Symptom Impact Questionnaire

2. Using the following scale, please indicate how much of a problem you have had with the following symptoms over the past week:

	No problem	Slight problems; generally mild or intermittent	Moderate, considerable problems; often present and/or at a moderate level	Severe, pervasive, continuous, life-disturbing problems
Fatigue	☐	☐	☐	☐
Trouble thinking or remembering	☐	☐	☐	☐
Waking up unrefreshed (tired)	☐	☐	☐	☐

3. Have you experienced any of the following symptoms over the past 6 months?

	Yes	No
Pain or cramps in lower abdomen	☐	☐
Depression	☐	☐
Headache	☐	☐

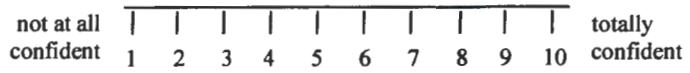
4. Overall, have the symptoms listed above in Questions 1-4 been present ("at a similar level") for at least the last three months?

☐ Yes ☐ No

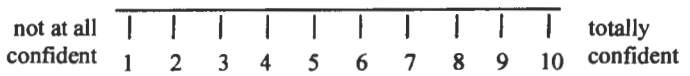
Stanford Chronic Disease Self-Efficacy Scales

We would like to know how confident you are in doing certain activities. For each of the following questions, please choose the number that corresponds to your confidence that you can do the tasks regularly at the present time.

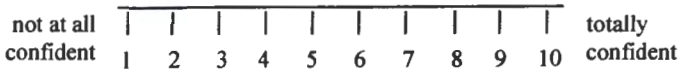
1. How confident are you that you can do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?



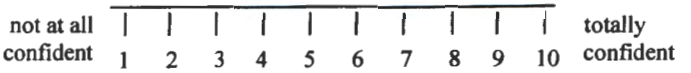
2. How confident are you that you can reduce the emotional distress caused by your health condition so that it does not affect your everyday life?



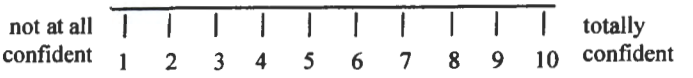
3. How confident are you that you can do things other than just taking medication to reduce how much your illness affects your everyday life?



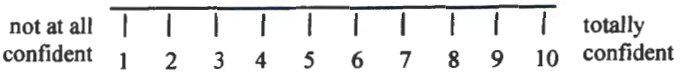
4. How confident are you that you can keep the fatigue caused by your disease from interfering with the things you want to do?



5. How confident are you that you can keep the physical discomfort or pain of your disease from interfering with the things you want to do?



6. How confident are you that you can keep any other symptoms or health problems you have from interfering with the things you want to do?



Pittsburgh Sleep Quality Index

Instructions: *The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month.* ***Please answer all questions.***

During the past month,

1. What time have you usually gone to bed? _____
2. How long (in minutes) has it taken you to fall asleep each night? _____
3. What time have you usually gotten up in the morning? _____
4. How many hours of actual sleep did you get at night? (This may be different than the number of hours you spend in bed.) _____

5. During the past month, how often have you had trouble sleeping because you…	**Not during the past month (0)**	**Less than once a week (1)**	**Once or twice a week (2)**	**Three or more times a week (3)**
a. Cannot get to sleep within 30 minutes				
b. Wake up in the middle of the night or early morning				
c. Have to get up to use the bathroom				
d. Cannot breathe comfortably				
e. Cough or snore loudly				
f. Feel too cold				
g. Feel too hot				
h. Have bad dreams				
i. Have pain				
j. Other reason(s), please describe:				
6. During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")				
7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?				
	No problem at all	**Only a very slight problem**	**Somewhat of a problem**	**A very big problem**
8. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?				
	Very good (0)	**Fairly good (1)**	**Fairly bad (2)**	**Very bad (3)**
9. During the past month, how would you rate your sleep quality overall?				

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	***Chance of Dozing or Sleeping***
Sitting and reading	____
Watching TV	____
Sitting inactive in a public place	____
Being a passenger in a motor vehicle for an hour or more	____
Lying down in the afternoon	____
Sitting and talking to someone	____
Sitting quietly after lunch (no alcohol)	____
Stopped for a few minutes in traffic	____

Work and Well-Being Survey

The following 17 statements are about how you feel at work. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, cross the "0" (zero) in the space after the statement. If you have had this feeling, indicate how often you felt it by crossing the number (from 1 to 6) that best describes how frequently you feel that way.

*Note: If for any reason you are not working, please understand "work/job" as your life responsibilities from day-to-day.

Never	Almost Never	Rarely	Sometimes	Often	Very Often	Always
0	**1**	**2**	**3**	**4**	**5**	**6**
Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

1. At my work, I feel bursting with energy.	0 1 2 3 4 5 6
2. I find the work that I do full of meaning and purpose.	0 1 2 3 4 5 6
3. Time flies when I am working.	0 1 2 3 4 5 6
4. At my job, I feel strong and vigorous.	0 1 2 3 4 5 6
5. I am enthusiastic about my job.	0 1 2 3 4 5 6
6. When I am working, I forget everything else around me.	0 1 2 3 4 5 6
7. My job inspires me.	0 1 2 3 4 5 6
8. When I get up in the morning, I feel like going to work.	0 1 2 3 4 5 6
9. I feel happy when I am working intensely.	0 1 2 3 4 5 6
10. I am proud of the work that I do.	0 1 2 3 4 5 6
11. I am immersed in my work.	0 1 2 3 4 5 6
12. I can continue working for very long periods at a time.	0 1 2 3 4 5 6
13. To me, my job is challenging.	0 1 2 3 4 5 6
14. I get carried away when I am working.	0 1 2 3 4 5 6
15. At my job, I am very resilient, mentally.	0 1 2 3 4 5 6
16. It is difficult to detach myself from my job.	0 1 2 3 4 5 6
17. At my work, I always persevere, even when things do not go well.	0 1 2 3 4 5 6

Life Events Checklist

Listed below are a number of difficult or stressful things that sometime happen to people. For each event, check one of the boxes to the right to indicate that: (a) It *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (d) you're *not sure* if it applies to you, or (e) it *doesn't apply* to you.

Mark *only one* item for any single stressful even you have experienced. For events that might fit more than one item description, choose the one that fits best.

Be sure to consider your *entire life* (growing up, as well as adulthood) as you go through the list of events.

Event	Happened to me (4)	Witnessed it (3)	Learned about it (2)	Not Sure (1)	Doesn't apply (0)
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)	N/A				
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else	*(Check here if you were directly involved)*				
17. Any other stressful event or experience					

PLQS: Please think about the symptoms you may have experienced in the past two weeks, *regardless of their cause*, and check in the appropriate boxes below:

	None	Mild	Moderate	Severe
Fever	☐	☐	☐	☐
Chills	☐	☐	☐	☐
Sweats	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Muscle Pain	☐	☐	☐	☐
Joint Pain	☐	☐	☐	☐
Joint Swelling	☐	☐	☐	☐
Numbness or tingling in hands or feet	☐	☐	☐	☐
Numbness or tingling in face or scalp	☐	☐	☐	☐
Muscle twitching	☐	☐	☐	☐
Headache	☐	☐	☐	☐
Eyes sensitive to light	☐	☐	☐	☐
Changes in vision clarity	☐	☐	☐	☐
Double vision	☐	☐	☐	☐
Drooping facial muscle (Bell's Palsy)	☐	☐	☐	☐
Drooping eyelid(s)	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐
Ringing in ears	☐	☐	☐	☐
Neck pain	☐	☐	☐	☐
Low back pain	☐	☐	☐	☐
Poor coordination	☐	☐	☐	☐
Memory changes	☐	☐	☐	☐
Difficulty finding words	☐	☐	☐	☐
Difficulty focusing or concentrating	☐	☐	☐	☐
Heart palpitations (irregular, fast or slow beats)	☐	☐	☐	☐
Difficulty breathing	☐	☐	☐	☐
Tender/enlarged lymph nodes	☐	☐	☐	☐
Sore throat	☐	☐	☐	☐
Changes in urination pattern (frequency, urgency)	☐	☐	☐	☐
Nausea	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Difficulty sleeping	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Irritability	☐	☐	☐	☐
Other symptoms, please specify: **a.** _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐