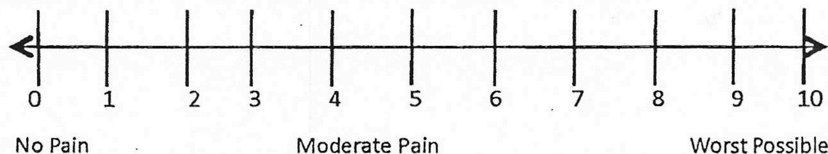
Patient Name:______________________________ Date of Birth:______________________________

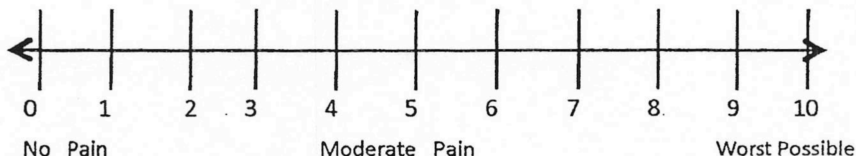
Signature:______________________________ Today's Date:______________________________

Please tell us about established symptoms that you are under care for and how they are affecting you today.

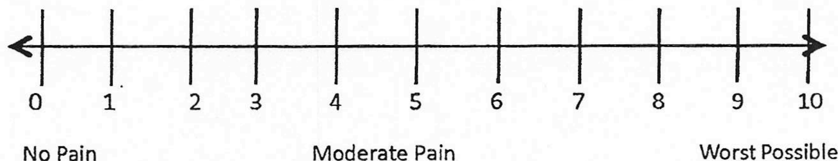
First Symptom:
____
____
____



Second Symptom:
____
____
____



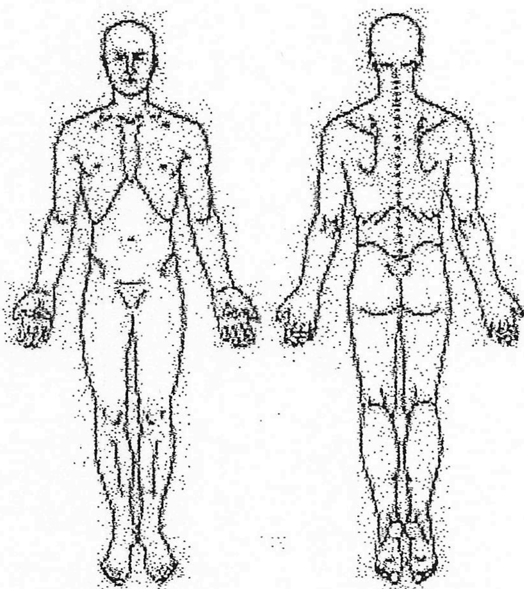
Third Symptom:
____
____
____



Please indicate any new symptoms or events here and note on the diagram below:

When did the new symptoms begin?____

How did they occur?
____
____
____
____
____



Please rate your new symptoms.