	Discomfort/ Pain	Stiffness	Weakness	Tiredness/ Fatigue	Headache	Dizziness	Vision Problems	Problems Sleeping	Irritability/ Crying	Difficulty Talking	Nausea/ Vomiting	Tingling/ Numbness	Strain/ Sprain	Difficulty Walking	Other: _____
1) Do you have any of the following? *(check all that apply)*	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
For each symptom you have, please answer the questions below and mark (●) where applicable.															
2) Does it interfere with your usual daily activities (e.g. work, school)?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
3) How many days have you had it?	____ days	____ days	____ days	____ days	____ days	____ days	____ days	____ days	____ days	____ days	____ days	____ days	____ days	____ days	____ days
4) Does it limit your ability to care for yourself (e.g. bathing, dressing, eating)?	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O

Thank you for participating in the study.
Please place this completed form in your provider's SafetyNET box.

***** Please Return the POST treatment comment form <u>up to one week</u> after your visit.*****

SafetyNET