## Page 2 (Turn Over To Start)

	DISCOMFORT/ PAIN	STIFFNESS	WEAKNESS	TIREDNESS/ FATIGUE	НЕАВАСНЕ	Dizziness	Vision Problems	PROBLEMS SLEEPING	IRRITABILITY/ CRYING	DIFFICULTY TALKING	NAUSEA/ VOMITING	Tingling/ Numbness	STRAIN/ SPRAIN	DIFFICULTY	Отнек:
Which side effect(s) did you have? (check all that apply)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
For each side effect you had,	please a	nswer th	e questi	ons belo	w and n	nark (•) v	vhere ap	plicable.							
2) Did you expect this to occur?  (Mark (•) for yes)	o	o	o	0	0	o	0	o	0	0	o	0	0	0	0
3) Did it interfere with your usual daily activities (e.g. work, school)?	0	0	o	0	0	0	0	0	0	0	0	0	0	0	0
Did it limit your ability to care for yourself (e.g. bathing, dressing, eating)?	o	0	0	o	0	0	0	0	0	0	0	0	0	0	0
5) Did you need to see a medical doctor because of it?	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6) Were you admitted to hospital because of it?	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7) How many hours after the therapy did it start?	, <del>(2 - 1</del> 4 <u>.</u>				_		-	<u> </u>		\$ <del></del>	9				
8) For how many days did it last? (check 'C' if it still continues)	days O C	days O C	days O C	days O C	days O C	days O C	days O C	days O C	days O C	days O C	days O C	days O C	days O C	days O C	days O C
If C, are you currently being treated for it?	О	0	0	0	0	0	0	0	0	0	0	0	0	0	0