

EXPRESSION OF STRESS SYMPTOMS

Please fill out all that apply that you are currently experiencing or have recurring episodes.

		Taking Drugs?				Taking Drugs?				Taking Drugs?			
		Yes	No			Yes	No			Yes	No		
GENERAL						LUNGS							
<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tingling Sensation	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Walking	<input type="checkbox"/>	<input type="checkbox"/>		
HEAD						<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Head Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR				<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Blacking Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strokes	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Migrains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	MUSCLE & BONE					
EYES						<input type="checkbox"/>	Heart Dx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Itching/Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Change in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ankle Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold Feet/Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Flashes in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Spots in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Calf Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EARS						<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	OTHER			
<input type="checkbox"/>	ringing/Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dislocations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Impaired Hearing	<input type="checkbox"/>	<input type="checkbox"/>	GASTRO-INTESTINAL				<input type="checkbox"/>	Urinating Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bloating/Gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain Urinating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MOUTH & THROAT						<input type="checkbox"/>	Liver Dx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed-Wetting	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Dx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Urgency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Infections			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Jaw/TMJ Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE					
<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>	SKIN				<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Goiter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NOSE						<input type="checkbox"/>	Itching/Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Therapy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Changes in Moles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Loss of Smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Temp. Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appetite Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excess Sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
									Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>