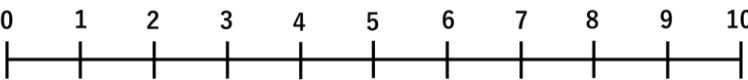
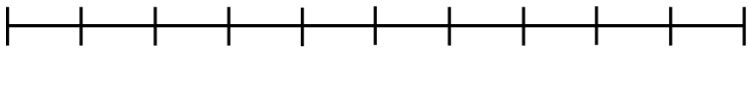
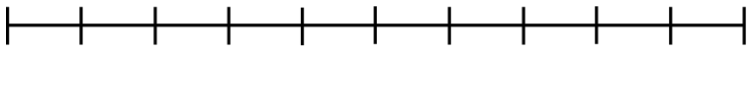
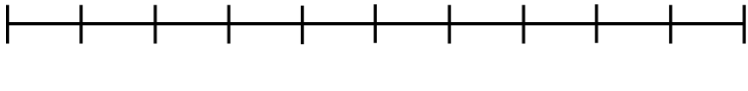
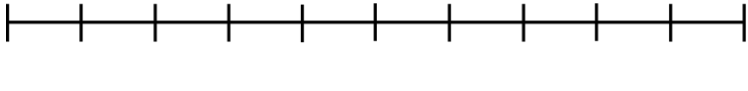
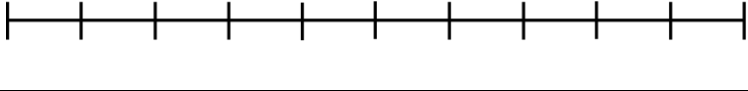
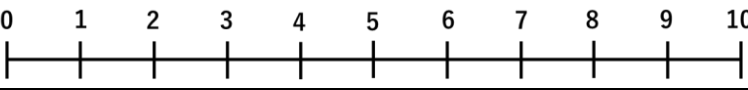
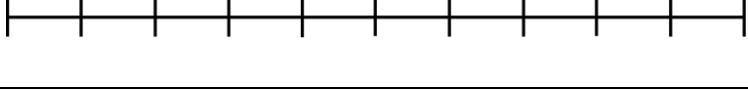
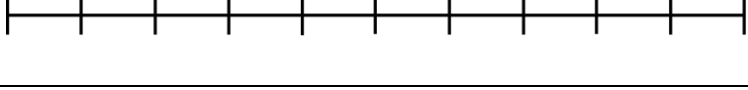
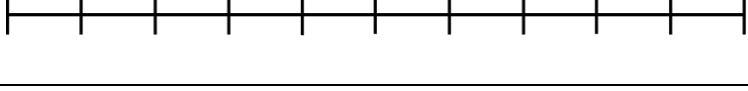
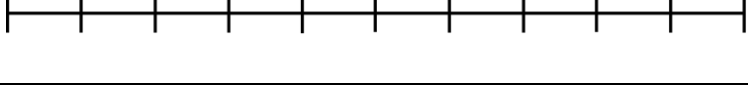
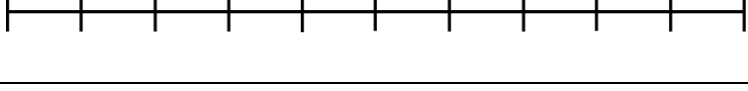
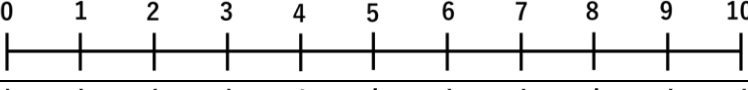
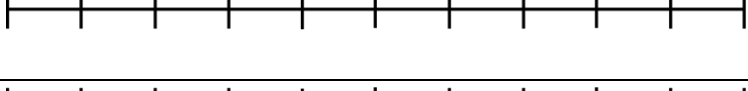
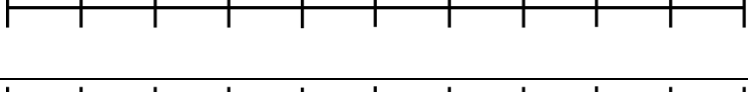
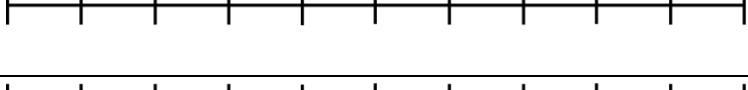
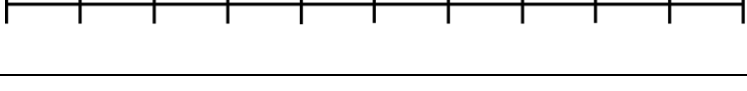


症状スケール（症状の強さの程度に○をつけてください。）

名前： _____、日付： _____ 年 _____ 月 _____ 日

(例)	症状の強さ（0：なし→10：我慢できないレベル） 0 1 2 3 4 5 6 7 8 9 10 
咽頭（のど）違和感	
後鼻漏	
咳	
痰	
首こり	
肩こり	0 1 2 3 4 5 6 7 8 9 10 
頭痛	
耳鳴り	
舌痛	
歯の知覚過敏	
多歯痛	
顎関節痛	0 1 2 3 4 5 6 7 8 9 10 
全身倦怠感	
めまい	
不眠・過眠	
起立性調節障害	

症状スケール（症状の強さの程度に○をつけてください。）

名前： _____、日付： _____ 年 _____ 月 _____ 日

記憶・集中力の低下	-----
下痢・腹痛など	0 1 2 3 4 5 6 7 8 9 10 -----
胃もたれ、胃痛など	-----
むずむず脚	-----
慢性疲労	-----
体の痛み	-----
その他	-----