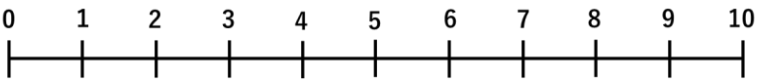
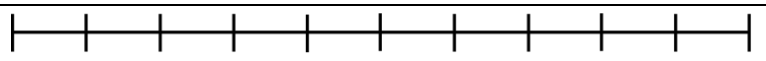
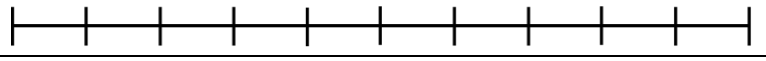
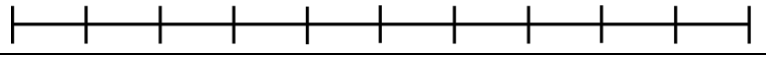
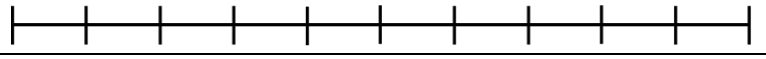
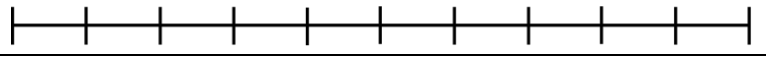
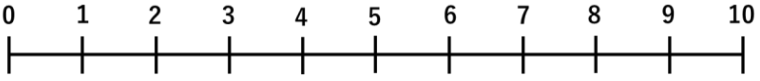
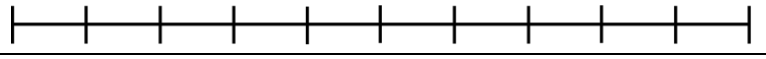
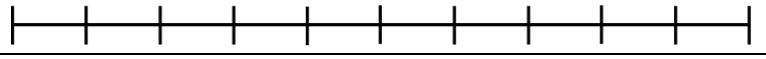
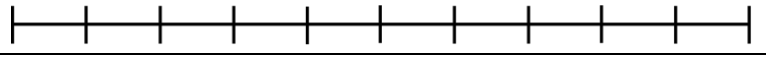
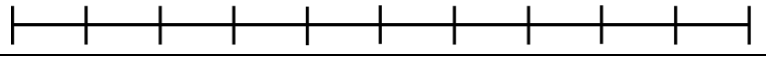
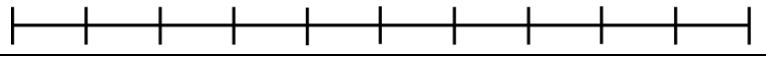
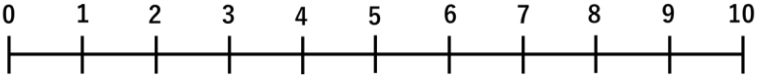
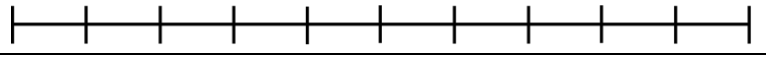
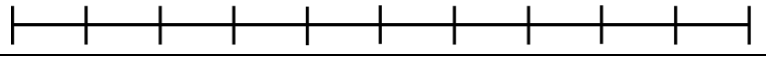
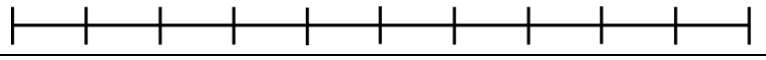
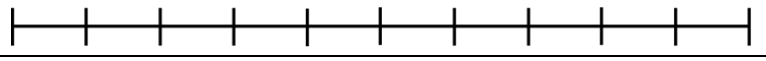
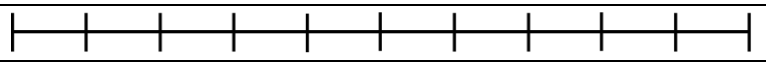
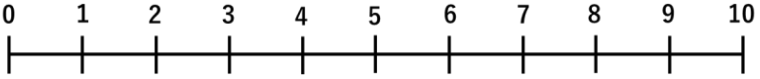
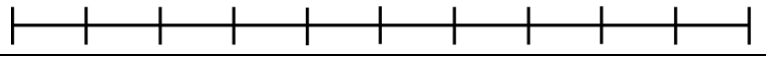
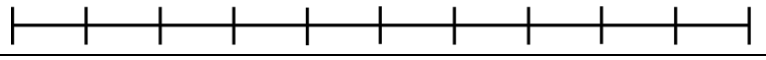
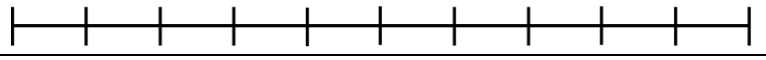
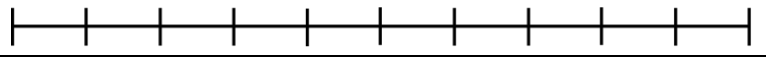
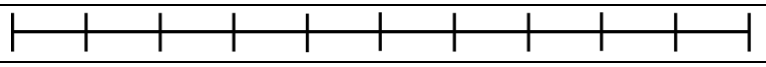
症状スケール（症状の強さの程度に〇をつけてください。）

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） 
咽頭（のど）違和感	
後鼻漏	
咳	
痰	
首こり	
肩こり	
頭痛	
耳鳴り	
舌痛	
歯の知覚過敏	
多歯痛	
顎関節痛	
全身倦怠感	
めまい	
不眠・過眠	
起立性調節障害	
記憶・集中力の低下	
下痢・腹痛など	
胃もたれ、胃痛など	
むずむず脚	
慢性疲労	
体の痛み	
その他