

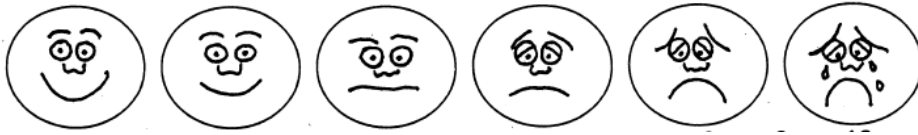
NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

PRE/POST

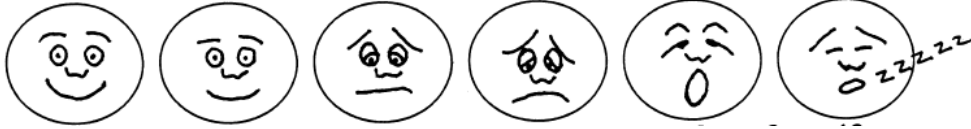
Headache:



0 1 2 3 4 5 6 7 8 9 10

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

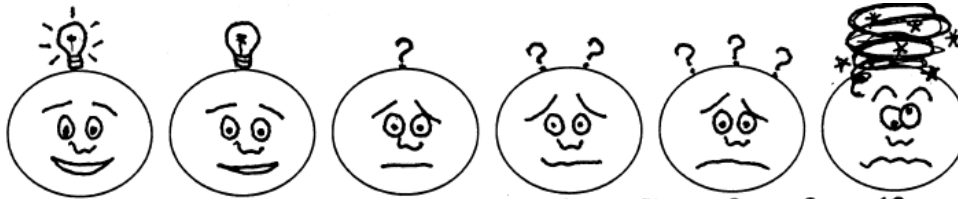
2. Fatigue:



0 1 2 3 4 5 6 7 8 9 10

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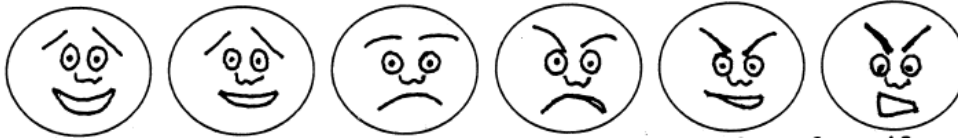
3. Concentration:



0 1 2 3 4 5 6 7 8 9 10

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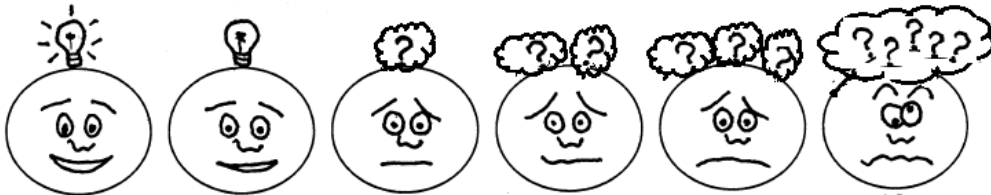
4. Irritability:



0 1 2 3 4 5 6 7 8 9 10

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5. Fogginess



0 1 2 3 4 5 6 7 8 9 10

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6. Sensitivity to Light



0 1 2 3 4 5 6 7 8 9 10

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7. Dizziness



0 1 2 3 4 5 6 7 8 9 10

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