

SHIATSU SYMPTOMS SURVEY

Check mark = sometimes

Filled in = frequently

<ul style="list-style-type: none"> <input type="checkbox"/> Fatigue/Tiredness Time of day _____ <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Lack of appetite <input type="checkbox"/> Abdominal bloating <input type="checkbox"/> Poor digestion <input type="checkbox"/> Stomach pain <input type="checkbox"/> Loose stool/diarrhea <input type="checkbox"/> Bruise easily <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Belching/ flatulence <input type="checkbox"/> Heartburn/reflux <input type="checkbox"/> Bad breath <input type="checkbox"/> Gum problems <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Overthinking/worrying <input type="checkbox"/> Inability to concentrate <input type="checkbox"/> Poor memory 	<ul style="list-style-type: none"> <input type="checkbox"/> Migraines <input type="checkbox"/> Eye problems <input type="checkbox"/> Dizziness/vertigo <input type="checkbox"/> Jaundice <input type="checkbox"/> Difficulty digestion greasy foods <input type="checkbox"/> Gallstones <input type="checkbox"/> Light coloured stools <input type="checkbox"/> Soft/brittle nails <input type="checkbox"/> Easily angered, agitated, frustrated <input type="checkbox"/> Depression <input type="checkbox"/> Muscle spasm/twitching <input type="checkbox"/> Tight tendons <input type="checkbox"/> Difficulty in making decisions <input type="checkbox"/> Lower rib pain <input type="checkbox"/> Bitter taste in mouth <input type="checkbox"/> Premature greying 	<ul style="list-style-type: none"> <input type="checkbox"/> Low back pain/weakness <input type="checkbox"/> Knee problems <input type="checkbox"/> Spine/joint dysfunction <input type="checkbox"/> Hearing problems <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Darkness under the eyes <input type="checkbox"/> Urinary dysfunction <input type="checkbox"/> Edema <input type="checkbox"/> Kidney infections/stones <input type="checkbox"/> Reproductive dysfunction <input type="checkbox"/> Loose teeth <input type="checkbox"/> Hair loss <input type="checkbox"/> Fearful
<ul style="list-style-type: none"> <input type="checkbox"/> Insomnia <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Colds hands/feet <input type="checkbox"/> Nightmares <input type="checkbox"/> Mental restlessness <input type="checkbox"/> Laughing for no reason <input type="checkbox"/> Chest pain/angina <input type="checkbox"/> Heart murmur <input type="checkbox"/> Sore tongue <input type="checkbox"/> Dizzy when getting up too quickly 	<ul style="list-style-type: none"> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Wheezing <input type="checkbox"/> Allergies <input type="checkbox"/> Cough (dry/wet) <input type="checkbox"/> Phlegmy <input type="checkbox"/> Throat problems <input type="checkbox"/> Constipation <input type="checkbox"/> Sadness 	<p>Men:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Prostate problems <p>Women:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pregnancy <input type="checkbox"/> PMS <input type="checkbox"/> Irregular periods <input type="checkbox"/> Absence of periods <input type="checkbox"/> Breast tenderness/lump <input type="checkbox"/> Cysts/fibroids <input type="checkbox"/> Menopause