Subject ID	Month	Day	Year	Week
0 0 0 0	0 0	0 0	0 0	0 0
1 1 1 1	1 1	1 1	1 1	1 1
2 2 2 2	2 2	2 2	2 2	2 2
3 3 3 3	3 3	3 3	3 3	3 3
4 4 4 4	4 4	4 4	4 4	4 4
5 5 5 5	5 5	5 5	5 5	5 5
6 6 6 6	6 6	6 6	6 6	6 6
7 7 7 7	7 7	7 7	7 7	7 7
8 8 8 8	8 8	8 8	8 8	8 8
9 9 9 9	9 9	9 9	9 9	9 9

Adequate Relief

ADEQUATE RELIEF OF IBS PAIN/DISCOMFORT MEASURE:

In the PAST 7 DAYS, have you had adequate relief of your IBS pain or discomfort?

1. **Yes**
2. **No**
3. **I have not had problem pain or discomfort in the last 7 days**

ADEQUATE RELIEF OF OVERALL BOWEL SYMPTOMS MEASURE:

In the PAST 7 DAYS, have you had adequate relief of your bowel symptoms? By bowel symptoms, we are referring to constipation and/or diarrhea, gas, a feeling of bloating, nausea, tenderness, urgent need to have a bowel movement, feeling that your bowel was not completely empty after a bowel movement, or other symptoms specific to the IBS problem that prompted you to seek treatment.

1. **Yes**
2. **No**
3. **I have not had problem bowel symptoms in the last 7 days**