SOMS - 7

Instructions: A number of different bodily complaints are listed below. Please indicate whether you have suffered from these symptoms within the PAST 7 DAYS. Consider only symptoms for which NO CLEAR CAUSES have been found by physicians, and which have affected your well-being.

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

I have read the instructions: Yes (1) No (0)

In the PAST 7 DAYS,
I suffered from the following complaints:

Yes	No	
1	0	1. Headaches
1	0	2. Stomach pain
1	0	3. Back pain
1	0	4. Joint pain
1	0	5. Pain in the legs and/or arms
1	0	6. Chest pain
1	0	7. Pain in the anus
1	0	8. Pain during sexual intercourse
1	0	9. Pain during urination
1	0	10. Nausea
1	0	11. Bloating
1	0	12. Stomach discomfort or churning feeling in the stomach
1	0	13. Vomiting (pregnancy excluded)
1	0	14. Bringing swallowed foods up again
1	0	15. Hiccups, or burning sensations in chest or stomach
1	0	16. Food intolerance
1	0	17. Loss of appetite
1	0	18. Bad taste in mouth, or excessively coated tongue
1	0	19. Dry mouth
1	0	20. Frequent diarrhea

(OVER PLEASE)