SEROVERA® AMP 500

SEROVERA® AMP 500
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______________________Your Full Name
______________________Diagnosis/Problem
______________________Phone Number
______________________Email Address

Recording your data takes very little time, and can result in dramatic reduction in your recovery time.

Every 30 days, please fax or mail completed data sheet to SEROVERA®
Note: Accuracy is absolutely critical to success
Circle one before sending: This is the 1st, 2nd, 3rd, 4th, 5th, 6th, data sheet I've completed.

Symptoms: Rate each symptom nightly with a number representing the level of intensity, 0 = non-existent, 10 = extreme pain, and all in between.
Write "NA" for symptoms you never experience.

Day:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Capsules Consumed:																															
Qty of Bowel Movements (24hr. Period):																															
Cramping:																															
Nausea:																															
Headache:																															
Rectal Bleeding:																															
Fatigue:																															
Number of Loose Stools:																															
Gas:																															
Bloating:																															
Passing Mucus:																															
Constipation:																															
Note: Enclosed is a Diet to Speedy Recovery - please adhere to it.:																															
Y=Yes I followed the diet. No=No, I did not.:																															

*Please note, this is for information purposes only, we DO NOT provide medical advice. Please include all prescription medications you are taking on a separate document.