

SUPPLEMENTS

Entry Question

1. Have you ever used herbs, mixtures, or other supplements that are taken by mouth specifically for your arthritis or joint symptoms? If you aren't sure, look ahead to the list below and then come back to this question.

No Please turn to the **purple** section, **Rubs, Lotions, Liniments, Creams and Oils**, on **page 9** to continue the booklet.

Yes Please answer the questions below about supplements you may take by mouth.

II.	a. Have you EVER used this supplement for your arthritis or joint symptoms?	b. Are you CURRENTLY using this supplement for your arthritis or joint symptoms? If yes, for how long?	c. Do you plan to CONTINUE to use this supplement for your arthritis or joint symptoms?
Devil's claw	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ (number of months)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eucalyptus	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ (number of months)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Fish oil and/or omega-3 fatty acids	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ (number of months)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Flaxseed oil	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ (number of months)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Garlic	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ (number of months)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Gelatin or Certo in grape juice	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ (number of months)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Ginger	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ (number of months)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Glucosamine	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ (number of months)	<input type="checkbox"/> No <input type="checkbox"/> Yes