

OMB Control #: 0925-xxx Expiration Date: mm/dd/yyyy

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Study name

Subject number

Date (mm/dd/yyyy)

Time (24 hour clock)

Experimenter initials

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Wellness Survey

Select one option for each symptom to indicate whether that symptom applies to you right now.

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General Discomfort

None	Slight	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Fatigue

None	Slight	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Headache

None	Slight	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Eye Strain

None	Slight	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Difficulty Focusing

None	Slight	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Salivation Increased

None	Slight	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Sweating

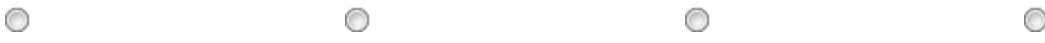
None	Slight	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Nausea

None	Slight	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Difficulty Concentrating

None	Slight	Moderate	Severe
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“Fullness of the Head” - Fullness of the head is an awareness of pressure in the head.

None	Slight	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Blurred Vision

None	Slight	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Dizziness with Eyes Open

None	Slight	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Dizziness with Eyes Closed

None	Slight	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Vertigo - Vertigo is experienced as loss of orientation with respect to vertical upright.

None	Slight	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Stomach Awareness - Stomach awareness is a feeling of discomfort which is just short of nausea.

None	Slight	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Burping

None	Slight	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Vomiting

None	Slight	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Are you experiencing any other symptoms RIGHT NOW?

- Yes
- No

What other symptom are you experiencing?

How severe is your other symptom?

Slight

Moderate

Severe

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Thank you for completing our questionnaire.

At this time, please notify the experimenter that you have finished.

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Experimenter initials

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We thank you for your time spent taking this survey.
Your response has been recorded.