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

Study name

Subject number

Date (mm/dd/yyyy)

Time (24 hour clock)

Experimenter initials

NEXT

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

Fatigue

None | Slight | Moderate | Severe

Headache

None | Slight | Moderate | Severe

Eye Strain

None | Slight | Moderate | Severe

Difficulty Focusing

None | Slight | Moderate | Severe

Salivation Increased

None | Slight | Moderate | Severe

Sweating

None | Slight | Moderate | Severe

Nausea

None | Slight | Moderate | Severe

Difficulty Concentrating

None | Slight | Moderate | Severe

○	○	○	○

“Fullness of the Head” - Fullness of the head is an awareness of pressure in the head.

None	Slight	Moderate	Severe
○	○	○	○

Blurred Vision

None	Slight	Moderate	Severe
○	○	○	○

Dizziness with Eyes Open

None	Slight	Moderate	Severe
○	○	○	○

Dizziness with Eyes Closed

None	Slight	Moderate	Severe
○	○	○	○

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

None	Slight	Moderate	Severe
○	○	○	○

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

None	Slight	Moderate	Severe
○	○	○	○

Burping

None	Slight	Moderate	Severe
○	○	○	○

Vomiting

None	Slight	Moderate	Severe
○	○	○	○

Are you experiencing any other symptoms RIGHT NOW?

- ○ Yes
- ○ No

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What other symptom are you experiencing?

How severe is your other symptom?

Slight | Moderate | Severe

BACK NEXT

Thank you for completing our questionnaire.

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

BACK NEXT

Experimenter initials

BACK NEXT

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