1.

1. Today's date:

2. Participant Name:

3. Participant ID code:

4. Age:

5. Gender:

- Female
- Male

6. Have you ever experienced any of the following conditions?

- Increased intercranial pressure
- Cerebral aneurysm
- Stroke or Transient Ischemic Attack
- Skull fracture
- Head injury
- Extreme weakness or fatigue

If so, when?

7. Are you currently pregnant?

- No
- Yes

If so, how many weeks?

8. Are you currently taking any medication?

- No
- Yes

If so, please indicate the name and dosage of the medication

9. Have you ever suffered an injury / physical trauma requiring treatment by a health care professional (eg. doctor, surgeon, physiotherapist, osteopath)?

- No
- Yes

10. If you answered 'yes' to question 9, please indicate the area/s of your body that has/have been injured. Tick as many boxes as required.

- Head
- Face
- Neck
- Shoulder
- Arm/Elbow
- Wrist/Hand
- Chest
- Back
- Abdomen/Groin
- Hip
- Leg/Knee
- Ankle/Foot

Please describe the severity of any injury sustained

11. Do you, or have you ever suffered from a long term illness, dysfunction, disorder, medical condition or disability lasting for a period of three months or more?

- No
- Yes

If so, please specify

12. Are you experiencing any physical discomfort or pain right now? Please indicate levels on the scale below.

- None at all
- Very mild
- Mild
- Moderate
- Severe
- Very severe
- The worst I have ever felt