**Side Effects Questionnaire**

**For experimenter:**

Date: \_\_\_\_\_\_\_\_\_\_\_ Additional comments:

Subject number: \_\_\_\_\_\_\_\_\_\_\_

Experiment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Experimenter name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For participant:**

Please indicate your current stress level

0 1 2 3 4 5 6 7 8 9 10

Not Stressed at all Very Stressed

Do you think / feel that the study that you have just experienced had any effect on your cognitive or emotional functioning?

Yes No

If yes, describe the effect as accurately as possible

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We would like to know if you experienced any of the following side effects of the study

Headache

None Mild Intense Extreme

Dizziness

None Mild Intense Extreme

Nausea

No Yes

Drowsiness / Fatigue

None Mild Intense Extreme

Shortness of breath

None Mild Intense Extreme

Coughing

No Yes

Throat irritation

None Mild Intense Extreme

Uncomfortable feeling (non-specific)

No Yes

Otherwise, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_