

# Enrollment Form

Please complete the survey below.

Thank you!

## Select a language

Select a language

- ☐ English  
☐ Français  
☐ Español

## Let's customize your experience

This application requires you to read text to answer questions. Do you have any vision-related requirements we can assist with?

- ☐ Yes  
☐ No

Yes, I would like to use some of the accessibility features of the app

- ☐ I would like to change the font size  
☐ I would like to change the font color (high contrast mode)  
☐ I would like to use a screen reader  
☐ I would like a person to read the text to me

This application may present some sound files for you to listen to. Do you have any hearing-related requirements we can assist with?

- ☐ Yes  
☐ No

Yes, I would like to use some of the accessibility features of the app

- ☐ I would like to turn up the volume  
☐ I would like to turn on closed captions  
☐ I would like to use haptic feedback (vibrations) instead of audio cues

This application requires you to navigate through the questions using a touch screen. Do you have any physical challenges we can accommodate?

- ☐ Yes  
☐ No

Yes, I would like to use some of the accessibility features of the app

- ☐ I would like to increase the size of the buttons  
☐ I have an alternative keyboard I'd like to connect instead  
☐ I would like to navigate the survey using voice commands instead of the touch screen

This application requires you to read text, answer questions, and follow directions. Do you have any cognitive challenges, including difficulty reading, that we can assist with?

- ☐ Yes  
☐ No

Yes, I would like to use some of the accessibility features of the app

- ☐ I would like the questions to be read to me using text-to-speech  
☐ I would like a person to read the text to me  
☐ I would like to speak my answers instead of typing them

**Who is participating in completing this survey?**

Check all that apply

- ☐ Self  
☐ Assistant  
☐ Parent/Caregiver

**Tell us about yourself**

What is your primary language?

- ☐ English  
☐ French  
☐ Spanish  
☐ Other (Please specify below)

If primary language is "other", please specify:

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Do you speak any additional language(s) fluently  
(similar to a native speaker)?

- ☐ None  
☐ English  
☐ French  
☐ Spanish  
☐ Other (please specify below)

If you speak any other languages fluently, please  
specify:

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What is your date of birth?

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**Do you have any of these conditions, diagnosed by a clinician?**

(Check all that apply if you currently have the condition)

**Voice Disorders**

	Unchecked	Checked
Glottic Insufficiency / Presbyphonia	<input type="radio"/>	<input type="radio"/>
Laryngeal Cancer	<input type="radio"/>	<input type="radio"/>
Laryngitis	<input type="radio"/>	<input type="radio"/>
Lesions of the vocal cord (nodule, polyp, cyst)	<input type="radio"/>	<input type="radio"/>
Muscle Tension Dysphonia (MTD)	<input type="radio"/>	<input type="radio"/>
Recurrent Laryngeal Papilloma (RRP)	<input type="radio"/>	<input type="radio"/>
Spasmodic Dysphonia / Laryngeal Tremor	<input type="radio"/>	<input type="radio"/>
Unilateral Vocal Fold Paralysis	<input type="radio"/>	<input type="radio"/>

### Neurological and Neurodegenerative Disorders

	Unchecked	Checked
Alzheimer's, Dementia, or Mild Cognitive Impairment	<input type="radio"/>	<input type="radio"/>
Amyotrophic Lateral Sclerosis (ALS)	<input type="radio"/>	<input type="radio"/>
Huntington's Disease	<input type="radio"/>	<input type="radio"/>
Parkinson's disease	<input type="radio"/>	<input type="radio"/>

### Mood and Psychiatric Disorders

	Unchecked	Checked
Alcohol or Substance Use Disorder	<input type="radio"/>	<input type="radio"/>
Anxiety Disorder	<input type="radio"/>	<input type="radio"/>
Attention-Deficit / Hyperactivity Disorder (ADHD)	<input type="radio"/>	<input type="radio"/>
Autism Spectrum Disorder (ASD)	<input type="radio"/>	<input type="radio"/>
Bipolar Disorder	<input type="radio"/>	<input type="radio"/>
Borderline Personality Disorder (BPD)	<input type="radio"/>	<input type="radio"/>
Depression or Major Depressive Disorder	<input type="radio"/>	<input type="radio"/>
Eating Disorder (ED)	<input type="radio"/>	<input type="radio"/>
Insomnia / Sleep Disorder	<input type="radio"/>	<input type="radio"/>
Obsessive-Compulsive Disorder (OCD)	<input type="radio"/>	<input type="radio"/>
Panic Disorder	<input type="radio"/>	<input type="radio"/>
Post-Traumatic Stress Disorder (PTSD)	<input type="radio"/>	<input type="radio"/>
Schizophrenia	<input type="radio"/>	<input type="radio"/>
Social Anxiety Disorder	<input type="radio"/>	<input type="radio"/>
Other Psychiatric Disorder	<input type="radio"/>	<input type="radio"/>

### Respiratory Disorders

	Unchecked	Checked
Asthma	<input type="radio"/>	<input type="radio"/>
Airway Stenosis (for example: bilateral vocal fold paralysis; laryngeal stenosis)	<input type="radio"/>	<input type="radio"/>
Chronic Cough	<input type="radio"/>	<input type="radio"/>
COPD	<input type="radio"/>	<input type="radio"/>
Obstructive Sleep Apnea (OSA)	<input type="radio"/>	<input type="radio"/>

**Pediatric Disorders**

	Unchecked	Checked
Autism Spectrum Disorder (ASD)	<input type="radio"/>	<input type="radio"/>
Speech Delay	<input type="radio"/>	<input type="radio"/>

**Eligible Studies**

Eligible Studies

- ☐ Voice Disorders
- ☐ Neurological and Neurodegenerative Disorders
- ☐ Mood and Psychiatric Disorders
- ☐ Respiratory Disorders
- ☐ Pediatric Disorders

**How did you learn about this study?**

How did you learn about this study?

- ☐ Through my physician/provider
- ☐ A flyer
- ☐ Social Media
- ☐ Bridge2AI Website
- ☐ At an event
- ☐ Other

If "At an event", please specify:

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If "Other", please specify:

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**Contact Information**

First Name

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Last Name

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Phone Number

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(###-###-####)

Email

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I want my contact information to be kept in a repository for this study which can be used to contact me to ask me to enroll in further studies or return important results. My information will not be shared with third parties.

- ☐ Yes
- ☐ No

**Review and Enroll**

Please review your answers reading all the way through the bottom and select an option. If you have any questions, you can still proceed with enrollment and ask or make changes at a later time.

- ☐ Enroll  
☐ Decline

Is Control Participant?

- ☐ Yes  
☐ No

Please select a reason for declining

- ☐ I am not interested in having my voice recorded  
☐ I do not have enough time today and want to be contacted later  
☐ I do not have enough time and do not want to be contacted later  
☐ I prefer not to share any health information for research  
☐ Other (Please specify)

If "Other" reason for declining enrollment, please specify:

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Enrollment Institution

- ☐ MIT  
☐ Mt. Sinai  
☐ SickKids  
☐ USF  
☐ VUMC  
☐ WCM

Researcher Email

\_\_\_\_\_

Enrollment Origin

- ☐ Bridge2AI App  
☐ Bridge2AI Enrollment Website

**Enrollment Form - Metadata**

Enrollment Form Started At

\_\_\_\_\_

Enrollment Form Completed At

\_\_\_\_\_

Enrollment Form Duration (seconds)

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