Subject ID_____ **Date**_____

DEMOGRAPHICS FORM

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1. **DOB** -N/A
2. **Age** _____
3. **Gender** (circle one) Male Female
4. **Height** _____
5. **Weight** _____
6. **Ethnicity** (circle one) Hispanic/Latino Non-Hispanic/Latino
7. **Race** (circle one) White/Caucasian Native Hawaiian/Pacific Islander
   Black/African American American Indian/Alaskan Native
   Asian Other_____
8. **Years of Education**_____
9. **Handedness**_____
10. **Is English your first language?** (Circle one) Yes No
11. **If no, how would you describe your proficiency?**
    a. Beginner
    b. Intermediate
    c. Advanced
    d. Native or bilingual proficiency

12. **Do you exercise?** Yes No

13. **If yes, about how many hours a week do you exercise?** _____

14. **Have you ever had electrical stimulation before?** (Circle one) Yes No
15. **If yes, how recently?**
    a. Within the past 7 days - Date: __/__ /__
    b. Within the past month
    c. Within the past 6 months
    d. Within the past year

Subject ID_____ **Date**_____

Session # _____

PRE-QUESTIONNAIRE

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1. How many hours of uninterrupted sleep did you get last night? _____
2. Rate your sleep quality for last night on a scale from 1 (much worse than normal) to 10 (much better than normal) _____
3. Did you wake up during last night? Y/N

   If Yes, how many times? _____
4. Did you smoke cigarettes in the last hour? Y/N
5. Have you eaten in the last hour? Y/N
6. Did you drink caffeinated beverages (e.g., coffee, tea, soda) today? Y/N

   If Yes, how long ago? _____

   If Yes, write the number of cans/ bottles of caffeinated drinks _____
7. Have you had alcohol in the last 24 hours? Y/N

   If Yes, when? _____

   If Yes, how much? _____
8. Did you exercise in the last 24 hours? Y/N

   If Yes, when? _____

   If Yes, how much (minutes/hours)? _____

Subject ID _____ **Date** _____

Session # _____

QUESTIONNAIRES

KAROLINSKA SLEEPINESS SCALE

Please, indicate your sleepiness during the 5 minutes before this rating through circling the appropriate description

1	Extremely alert
2	Very alert
3	Alert
4	Rather alert
5	Neither alert nor sleepy
6	Some signs of sleepiness
7	Sleepy, but no effort to keep awake
8	Sleepy, some effort to keep awake
9	Very sleepy, great effort to keep awake, fighting sleep

Please rate the way you feel in terms of overall physical discomfort.
Rate your feelings as they are <u>at the moment</u>. Circle the appropriate point of the scale.

Subject ID _____ **Date** _____

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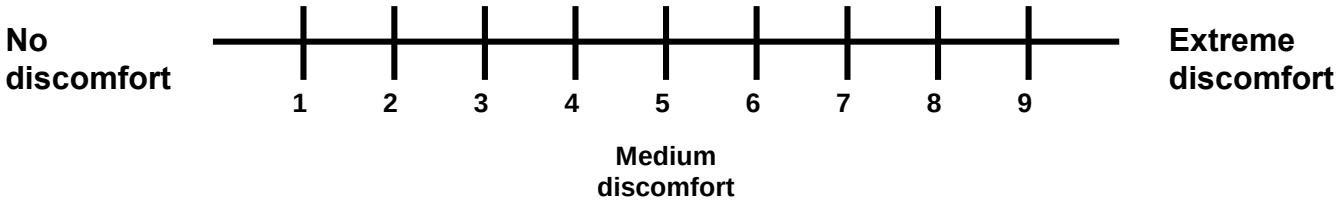
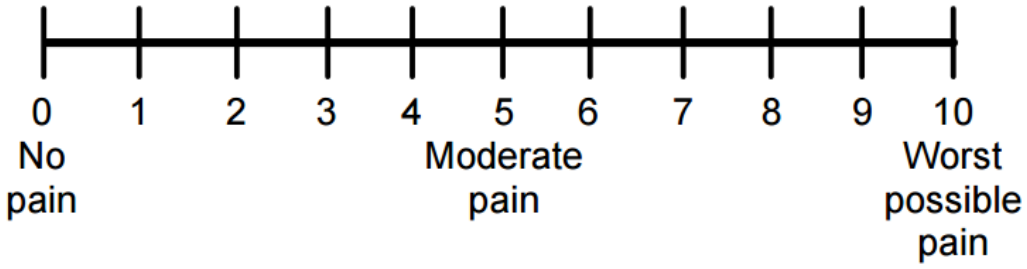


Please rate the sensation in terms of overall pain.
Rate your feelings as they are <u>at the moment</u>. Circle the appropriate point of the scale.



Subject ID _____ **Date** _____

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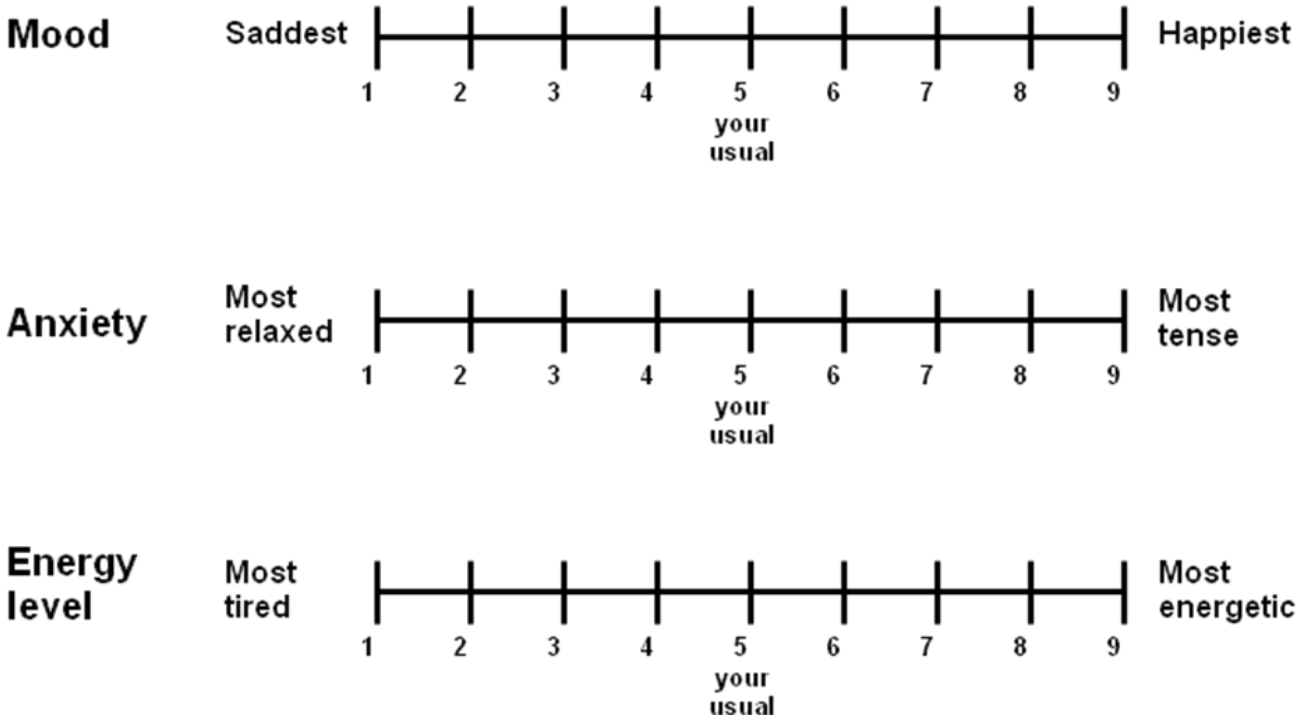
Please rate the way you feel in terms of the dimensions given below.
Rate your feelings as they are <u>at the moment</u>. Circle the appropriate point of the scale.



Subject ID_____ **Date**_____

Session # _____

ADVERSE EVENT REPORTING FORM

Notes on protocol:

1-Absent 1-None
2-Mild 2-Remote
3-Moderate 3-Possible
4- Severe 4-Probable
5-Definite

Did you experience any of the following symptoms/side effects?	**Severity**	**Relationship**	**Notes**
Headache			
Neck Pain			
Scalp Pain			
Tingling			
Burning sensation			
Skin redness			
Sleepiness			
Trouble concentrating			
Acute Mood Changes (indicate Direction)			
Other (specify)			