Participant ID­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_

Date and Time\_\_\_\_\_\_\_\_\_

**Smell Test**

1. Rate the *intensity* of the smell

None Very Intense

1 2 3 4 5 6 7

2. What do you smell?

Body Odor

Smoke

Food, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_

Hygiene Products, explain \_\_\_\_\_\_\_\_\_\_\_\_\_

Other, explain\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Rate the *pleasantness* of the smell

Very unpleasant Very pleasant

1 2 3 4 5 6 7