









SUBJECT ID: 1001Visit # (A-E) CVISIT DATE: 8/1/21DATE INFORMED CONSENT SIGNED: 7/27/21

Participant Worksheet

About once per minute, you will be asked to mark the level of pain or discomfort you are experiencing. Marks should be placed in the second column, after making a mark in one box, please move down to the next box. For your reference, there is a visual analog scale (VAS) chart with brief descriptions of VAS levels below. In columns 3, 4, or 5, please mark the **first** distension you experience the following sensations: first sensation, urge to defecate, and maximum tolerance.

0	1	2	3	4	5	6	7	8	9	10
										
No pain	Mild, annoying pain	Nagging, uncomfortable, troublesome pain	Distressing, miserable pain	Intense, dreadful, horrible pain	Worst possible, unbearable, excruciating pain					

SUBJECT ID: _____ Visit # (A-E) _____ VISIT DATE: ____/____/____

DATE INFORMED CONSENT SIGNED: ____/____/____

Distention 1:

Distention Number	VAS score (0-10)	First sensation	Urge to defecate	Maximum tolerance
1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SUBJECT ID: _____ Visit # (A-E) _____ VISIT DATE: ____/____/____

DATE INFORMED CONSENT SIGNED: ____/____/____

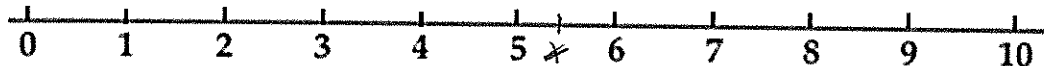
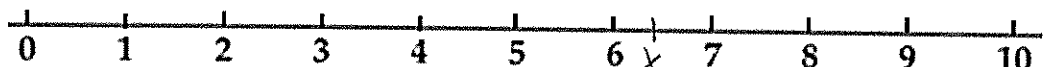

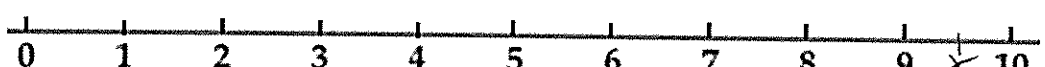
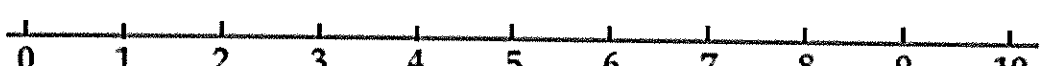

11		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Distention 2:

Distention Number	VAS score (0-10)	First sensation	Urge to defecate	Maximum tolerance
1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SUBJECT ID: _____ Visit # (A-E) _____ VISIT DATE: ____/____/____

DATE INFORMED CONSENT SIGNED: ____/____/____

7		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>