

Pre-screening

* Required

1. **Gender:** *

Mark only one oval.

- ☐ Male
- ☐ Female
- ☐ Other

2. **Age:** *

3. **How do you currently feel?**

Check all that apply.

- ☐ Happy
- ☐ Sad
- ☐ Anxious
- ☐ Relaxed
- ☐ Neutral
- ☐ Other:

4. **How many times have you previously experienced VR?** *

Mark only one oval.

- ☐ Never
- ☐ 1-2 Times
- ☐ 3+ times

5. **Do you have any issues viewing 3D?** *

Mark only one oval.

- ☐ Yes
- ☐ No

6. **Do you have any known heart problems? (ex: heart arrythmia)** *

Mark only one oval.

- ☐ Yes
- ☐ No

7. **Have you ever experienced ASMR before? ****Mark only one oval.*

- ☐ Yes
- ☐ No

8. **If yes, what triggers your ASMR?***Check all that apply.*

- ☐ Whispering
- ☐ Personal attention (e.g. face touching)
- ☐ Crisp sounds (e.g. tapping, crinkling, plastic)
- ☐ Slow movements
- ☐ Watching repetitive tasks (e.g. towel folding)
- ☐ Other:

9. **Do you watch ASMR videos? ****Mark only one oval.*

- ☐ Yes
- ☐ No

10. **Please select the statement that most applies to you:***Mark only one oval.*

- ☐ When watching ASMR videos I feel a change in my mood only when I experience tingling
- ☐ When watching ASMR videos I feel a change in my mood whether or not I experience tingling
- ☐ When watching ASMR videos I feel no change in my mood

ASMR VR11. **I felt as though I was in the virtual environment.***Mark only one oval.*

	1	2	3	4	5	6	7	
Disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Agree

12. **I felt as though the salon was a real place that I was visiting.***Mark only one oval.*

	1	2	3	4	5	6	7	
Disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Agree

13. Did you feel a change in your mood after the experience?*Mark only one oval.*☐ Yes☐ No**14. If yes, how did the experience make you feel?***Check all that apply.*☐ Happy☐ Sad☐ Anxious☐ Relaxed☐ Neutral☐ Other:**15. What aspects of the experience affected your mood?**

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16. Did you experience tingles?*Mark only one oval.*☐ Yes☐ No**17. If yes, what triggered your ASMR?***Check all that apply.*☐ Whispering☐ Personal attention (e.g. face touching)☐ Crisp sounds (e.g. tapping, crinkling, plastic)☐ Slow movements☐ Watching repetitive tasks (e.g. hand waving)☐ Other:**ASMR Audio**

18. Did you feel a change in your mood after the experience?*Mark only one oval.*☐ Yes☐ No**19. If yes, how did the experience make you feel?***Check all that apply.*☐ Happy☐ Sad☐ Anxious☐ Relaxed☐ Neutral☐ Other:**20. What aspects of the experience affected your mood?**

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21. Did you experience tingles?*Mark only one oval.*☐ Yes☐ No**22. If yes, what triggered your ASMR?***Check all that apply.*☐ Whispering☐ Personal attention (e.g. face touching)☐ Crisp sounds (e.g. tapping, crinkling, plastic)☐ Slow movements☐ Watching repetitive tasks (e.g. hand waving)☐ Other: