**DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TIME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARTICIPANT NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PARTICIPANT ID #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex:** MALE FEMALE **Height:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dominant Hand** (Circle One): RIGHT LEFT BOTH **Dominant Eye:** RIGHT LEFT

**Rhine Test:** POSITIVE NEGATIVE **Weber Test:** POSITIVE NEGATIVE (Right Left)

* **HAVE YOU HAD ANY RECENT HEAD INJURIES OVER THE PAST 12 MONTHS?**  YES NO

IF YES: DATE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU HAD MORE THAN ONE CONCUSSION? IF SO, HOW MANY? \_\_\_\_\_\_\_\_\_\_

* **DO YOU HAVE ANY NECK PAIN CURRENTLY?**  YES NO
* **DO YOU WEAR CORRECTED LENS FOR READING?**  YES NO
* **DO YOU SUFFER FROM HEADACHES?** YES NO

If yes, how often? 0 – 1 time/ month 2 – 4 times/week 5 or more times/ month

* **HOW MANY HOURS SLEEP DID YOU HAVE LAST NIGHT?** \_\_\_\_\_\_\_\_\_\_\_\_
* **DO YOU HAVE TROUBLE SLEEPING AT NIGHT?** YES NO

**PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING OVER THE LAST 24 HOURS.**

* CAFFIENE YES NO
* MEDICATION TO AID SLEEP YES NO
* HEADACHE YES NO
* ALCOHOL YES NO

**TEXAS STATE STUDENT:** YES NO

**PRIMARY PHYSICIAN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TEL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **DO YOU WANT YOUR RESULTS SHARED WITH YOUR PHYSICIAN?** YES NO

**THANK YOU FOR VOLUNTEERING TO HELP WITH THIS PROJECT!**