Clinical Trial Case Report Subject Questionnaire

Date:_____

Serial Number:_____ Subject Initial:_____ Age:_____

This questionnaire aims to obtain feedback from the clinical trial. It takes about 10 to 15 minutes to complete. Please take your time and answer all questions carefully and completely.

A. I would like to ask you about your general health

How would you rate your health in general	Excellent / Good / Neutral / Fair / Poor
How would you rate your health in general comparing to one year ago?	Much better / Better / Same / Worse / Much Worse

Do you have any stroke related visual impairment or problem? (e.g., reduce visual field, neglect or double vision)	Yes / No
Do you have any impaired sensation on your affected hand? (e.g., able to differentiate temperature, tactile sensation, location, etc)	Yes / No

Did you have any pain during the past 4 week?	Yes / No	
How bad was your pain during the past 4 weeks?	Very Severe / Severe / Moderate / Some / None	
Were you able to describe your pain?	Location:	
	Type:	Sharp / Dull / Shooting / Numb / Bone
	Onset time:	Morning / Afternoon / End of the day / Midnight
	Duration:	<10 mins / <30mins / <1hour / >1hour
How much did the pain interfere your normal work?	Extremely / Quite a bit / Moderate / A little bit / None	

B. I would like to ask you about some experiences or senses you may have had.

1. Did you have any unexpected experience or sense during the clinical trial?
   ◯ Yes ◯ No

2. Did you have this kind of experience or sense before the clinical trial?
   ◯ Yes ◯ No

3. Did this experience or sense keep presenting after the clinical trial?
   ◯ Yes ◯ No

4. Are you able to describe this sense that you experienced?

   Time of onset:

   ◯ Early Morning (in bed) ◯ Day time ◯ Evening
   ◯ Night before sleep ◯ Midnight

   Type of sense:

   ◯ Muscle contraction ◯ Hand/fingers movement ◯ Deep pressure
   ◯ Light touch ◯ Warm and cold ◯ Needle
   ◯ Numbness ◯ Tingling ◯ Shooting pain
   ◯ Dulled pain ◯ Muscle spasm ◯ Others: _____

   Duration:

   ◯ Less than 10 minutes ◯ 10 to 30 minutes ◯ 30 to 60 minutes
   ◯ More than 1 hour ◯ Never

   Frequency:

   ◯ Almost every day ◯ Several times a week ◯ About once a week
   ◯ Two or three times a month ◯ About once a month ◯ Less than once a month
   ◯ Never

5. How intense was the sense?

   ◯ Not at all intense ◯ Not that intense ◯ Somewhat intense
   ◯ Quite intense ◯ Very intense

6. Did you see any physical movement of your hand?

   ◯ Yes ◯ No ◯ Not sure

7. Do you think the sense was a dream or hallucination?

   ◯ Yes ◯ No ◯ Not sure

8. How often did you record this sense?

   ◯ Almost every time ◯ Several times a week ◯ About once a week
   ◯ Two or three times a month ◯ About once a month ◯ Less than once a month
   ◯ Never

9. Did your family members or carers notice this sense?

   ◯ Yes ◯ No

10. Did the sense make any impact on your daily living?

    ◯ Yes, Negative impact ◯ Yes, Positive impact ◯ No impact

C. I would like to ask you about the clinical trial experience you may have had.

(Please rate your experience or feeling with a scale of 1 to 10.)

1. How much were you able to control the robotic device?

|_____|_____|_____|_____|_____|_____|_____| _____|_____|_____|
Not at all Somewhat Completely

2. How compelling was your sense of objects moving through space?

|_____|_____|_____|_____|_____|_____|_____| _____|_____|_____|
Not Compelling Moderately Compelling Very Compelling

3. How much did the robotic devices interfere with the performance of assigned tasks?

|_____|_____|_____|_____|_____|_____|_____| _____|_____|_____|
Not at all Moderate A lot

4. How well could you concentrate on the assigned tasks during clinical trial?

|_____|_____|_____|_____|_____|_____|_____| _____|_____|_____|
Not at all Moderate Completely

5. Did you learn new techniques that enabled you to improve your performance?

|_____|_____|_____|_____|_____|_____|_____| _____|_____|_____|
Not agree Somewhat agree Completely agree

D. I would like to ask you about some post-clinical trial experiences you may have had.

(Please rate your experience or feeling with a scale of 1 to 10.)

1. I have improved in Activities of Daily Living performance after the clinical trial

|_____|_____|_____|_____|_____|_____|_____| _____|_____|_____|
Completely Disagree Completely Agree

2. I am more aware of my affected hand than before

|_____|_____|_____|_____|_____|_____|_____| _____|_____|_____|
Completely Disagree Completely Agree

3. I use my affected hand more than before

|_____|_____|_____|_____|_____|_____|_____| _____|_____|_____|
Completely Disagree Completely Agree

4. I am more able to control my affected hand than before

|_____|_____|_____|_____|_____|_____|_____| _____|_____|_____|
Not Agree Completely Agree

5. I have more confidence in performing Activities of Daily Living than before

|_____|_____|_____|_____|_____|_____|_____| _____|_____|_____|
Completely Disagree Completely Agree

6. I feel the sense is meaningful to me

|_____|_____|_____|_____|_____|_____|_____| _____|_____|_____|
Completely Disagree Completely Agree

E. I would like to ask you about motor activity performance before and after the clinical trial. (Please rate your experience or feeling with a scale of 0 to 5.)

	Before Amount Scale / How Well Scale	**After** Amount Scale / How Well Scale
Carrying objects		
1. Picking up glasses, bottles, cups or cans	____/____	____/____
2. Picking up small items (cubes, marble and etc.)	____/____	____/____
3. Carrying towels or clothes	____/____	____/____
Self-care		
4. Washing and drying body	____/____	____/____
5. Combing your hair	____/____	____/____
6. Squeezing tooth paste or lotion cream	____/____	____/____
Functional activities		
7. Pouring water from bottle into cups	____/____	____/____
8. Writing or drawing with pen on paper	____/____	____/____
9. Wiping table with a cloth	____/____	____/____
10. Eating with fork, knife or spoon	____/____	____/____

Amount Scale:

- Not used 0
- Very rarely 1
- Rarely 2
- Half pre-stroke 3
- ¾ pre-stroke 4
- Same as pre-stroke 5

How Well Scale:

- Never 0
- Very poor 1
- Poor 2
- Fair 3
- Almost normal 4
- Normal 5