Self Rotation Study

Pre Questionnaire

Subject #:

Please fill in the blanks or circle the one best response unless otherwise noted. If more space is needed, please note the question number and continue on the back of each sheet. Remember, filling out this questionnaire is voluntary. Skipping any question that makes you feel uncomfortable will not exclude you from the study.

1. What is your date of birth? _____ (month / year)

2. Are you: Male Female

3. Thinking about how you feel today, how would you describe your current physical well-being?

    a. Excellent
    b. Good
    c. Average
    d. Fair
    e. Poor

4. Thinking about how you feel today, how would you describe your current mental well-being?

    a. Excellent
    b. Good
    c. Average
    d. Fair
    e. Poor

5. Do you feel sick right now?

    a. Yes (If yes, please inform the research assistant.)
    b. No

6. Has anything happened in your life or have any events occurred recently that might influence how you are feeling, your comfort in taking part in the experiment or your ability to drive today?

    a. Yes (If yes, please describe briefly below.)
    b. No

_____

_____

7. Have you drunk coffee today? Yes No
8. Have you been working out today?
   - Yes (If yes, please describe briefly below.)
   - No

Athletics History

9. Have you ever practiced any sports/activities requiring balance or coordination?
   - Yes (If yes, please describe briefly below: how long, competition/leisure…)
   - No

10. Have you ever practiced any activities involving self-rotations (diving, free style skiing, water synchronization dance)?
    - Yes (If yes, please describe briefly below.)
    - No

11. On a scale from 1-10 (1 being not fit at all, and 10 being extremely fit) rate your perceived level of fitness?

12. On a scale from 1-10 (1 not having any sense of balance at all, and 10 having a perfect sense of balance) rate your perceived sense of balance?

13. On a scale from 1-10 (1 not having any sense of coordination at all, and 10 having a perfect sense of coordination) rate your perceived sense of coordination?

14. Have you ever played a music instrument?
    - Yes (If yes, please describe briefly below: how long, competition/leisure…)
    - No