

PATIENT FORM														
What is your:		Please fill in or tick the right box as appropriate.												
1	Date of birth	<i>(Day.Month.Year)</i>												
2	Gender	<input type="checkbox"/>	Male											
		<input type="checkbox"/>	Female											
3	Current living situation	<input type="checkbox"/>	Alone											
		<input type="checkbox"/>	With spouse/partner											
		<input type="checkbox"/>	With spouse/partner and children < 18 years old											
		<input type="checkbox"/>	With children < 18 years old											
		<input type="checkbox"/>	With other adult(s)											
		<input type="checkbox"/>	In an institution											
		<input type="checkbox"/>	Other (please specify)_____											
4	Highest completed level of education	<input type="checkbox"/>	Primary school											
		<input type="checkbox"/>	Secondary school / high school											
		<input type="checkbox"/>	College/university											
		<input type="checkbox"/>	Other (please specify)_____											
5	Nationality													
<b>Symptoms. Please mark the number that best describes how you feel NOW:</b>														
6	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7	No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
8	No Tiredness <i>(Tiredness = lack of energy)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
9	No Drowsiness <i>(Drowsiness = feeling sleepy)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
10	No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
11	No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
12	No Vomiting	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Vomiting	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
13	No Constipation	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Constipation	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
14	No Anxiety <i>(Anxiety = feeling nervous)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
15	No Depression <i>(Depression = feeling sad)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
16	Best Sleep	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Sleep	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
17	Best Wellbeing <i>(Wellbeing = how you feel overall)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		