Suppl. Table 1

Date_____ Symptom Questionnaire Name_____

We would like to know if you suffer from any of the symptoms mentioned below.

For each question please circle the one that matches your answer best.

0 = not experienced at all

1 = no longer a problem

2 = a mild problem

3 = a moderate problem

4 = a severe problem

Do you currently (during the last 24 hours) suffer from:

1. Headaches	0	1	2	3	4
2. Feelings of dizziness	0	1	2	3	4
3. Nausea and/or vomiting	0	1	2	3	4
4. Noise sensitivity (easily upset by loud noise)	0	1	2	3	4
5. Sleep disturbance	0	1	2	3	4
6. Fatigue, tiring more easily	0	1	2	3	4
7. Being irritable, easily angered	0	1	2	3	4
8. Feeling depressed or tearful	0	1	2	3	4
9. Feeling frustrated or impatient	0	1	2	3	4
10. Forgetfulness, poor memory	0	1	2	3	4
11. Poor concentration	0	1	2	3	4
12. Taking longer to think	0	1	2	3	4
13. Blurred vision	0	1	2	3	4
14. Light sensitivity (easily upset by bright light)	0	1	2	3	4
15. Double vision	0	1	2	3	4
16. Restlessness	0	1	2	3	4

17. Stress susceptibility	0	1	2	3	4
18. Problems doing different things simultaneously	0	1	2	3	4
19. Emotional dullness	0	1	2	3	4
20.Impulsiveness	0	1	2	3	4
21. Orientation problems in new surroundings	0	1	2	3	4
22. Neck pain	0	1	2	3	4
23. Other pains	0	1	2	3	4
If this is a problem, in what part of the body? _____					
24. Balance problems	0	1	2	3	4
25. Clumsiness	0	1	2	3	4
26. Numbness	0	1	2	3	4
If this is a problem, in what part of the body? _____					
27. Decreased sense of smell	0	1	2	3	4
28. Decreased sense of taste	0	1	2	3	4
29. Tinnitus	0	1	2	3	4
30. Increased yawning	0	1	2	3	4
31. Easily falling asleep when inactive	0	1	2	3	4
32. Increased sensitivity to cold	0	1	2	3	4
33. Increased sweating	0	1	2	3	4
If this is a problem, in what part of the body? _____					
34. Alcohol sensitivity	0	1	2	3	4
35. Hypoactive sexual desire	0	1	2	3	4

Do you experience other difficulties?

Please specify, and assess as above:

36._____	0	1	2	3	4
37. _____	0	1	2	3	4
38. _____	0	1	2	3	4
39. _____	0	1	2	3	4