

Vital Signs

Please mark if evaluation was not done

Any significant findings after the start of the study drug should be recorded on the Adverse Events page.

Please circle the correct measurement, when applicable.

Height: _____ cm. or inches

Weight _____ kg or lb

Sitting Pulse _____ bpm

**Sitting
Blood Pressure** _____/_____
systolic/diastolic
MmHg

Respirations _____/minute

Temperature _____ degrees Centigrade or Fahrenheit

Notes: _____

Participant is to complete the following separate survey forms:

Symptom Check List 90

SCL-90 Complete Incomplete Reason: _____

Profile of Mood States

POMS Complete Incomplete Reason: _____

State – Trait Anxiety Inventory

STAI Complete Incomplete Reason: _____

Pittsburgh Sleep Quality Index

PSQI Complete Incomplete Reason: _____

GSRS Complete Incomplete Reason: _____

CGI Complete Incomplete Reason: _____

Somatic Symptom Checklist

SSC Complete Incomplete Reason: _____

HADS Complete Incomplete Reason: _____

FBDSI Complete Incomplete Reason: _____

Bowel Disease Questionnaire Version 6

BDQ-6 Complete Incomplete Reason: _____

Semi – Structured Interview

Complete Incomplete Reason: _____

Eating Disorder Examination Questionnaire

EDE-Q Complete Incomplete Reason: _____

Trauma Questionnaire

Complete Incomplete Reason: _____

Early Trauma Inventory Self Report – Short Form

ETISR – SF Complete Incomplete Reason: _____

Changes:

Were any changes made on any of the above questionnaires?

NO YES (If yes, see below)

If yes, study coordinator initial and date HERE that the changes were made by the study participant at the time of completion of questionnaires. _____

Study coordinator initial

____|____|____|____|____|____|
Month Day Year