SAPIEN LABS

Session State of Mind Form

Subject Name: .... **Email:** ....

Year of Birth: .... **Gender:** .... *M* .... *F* .... *X*

Location of Recording (Select all that apply within any ***one*** column)**:**

○ *Indoors - office*	○ *Outdoors - sheltered*
○ *Indoors - home*	○ *Outdoors - nature dominant*
○ *Indoors - lab*	○ *Outdoors - urban dominant*
○ *Indoors - other*	○ *Outdoors - open space*

1. Please indicate if you have you consumed/used any of the following substanses in the last *twenty four* hours?

Substance				Substance			
1. Coffee	○ *No*	○ *Yes*	.... *hours ago*	10. Tranquilizers	○ *No*	○ *Yes*	.... *hours ago*
2. Tea	○ *No*	○ *Yes*	.... *hours ago*	11. Acetamenophin	○ *No*	○ *Yes*	.... *hours ago*
3. Mate	○ *No*	○ *Yes*	.... *hours ago*	12. Ibuprofen	○ *No*	○ *Yes*	.... *hours ago*
4. Redbull	○ *No*	○ *Yes*	.... *hours ago*	13. Aspirin	○ *No*	○ *Yes*	.... *hours ago*
5. Caffeinated Soda (Coke/ Pepsi/Mountain Dew etc.)	○ *No*	○ *Yes*	.... *hours ago*	14. Sleeping Pills	○ *No*	○ *Yes*	.... *hours ago*
6. Alcohol	○ *No*	○ *Yes*	.... *hours ago*	15. Other (Please specify)	○ *No*	○ *Yes*	.... *hours ago*
7. Cannabis	○ *No*	○ *Yes*	.... *hours ago*				
8. Opium	○ *No*	○ *Yes*	.... *hours ago*	16. Other (Please specify)	○ *No*	○ *Yes*	.... *hours ago*
9. Amphetamines	○ *No*	○ *Yes*	.... *hours ago*				

2. Are you on any regular medication? ○ *Yes* ○ *No*

Please List *1.* .... *Last Taken* ....

2. ....

3. ....

3. If female, are you currently using oral contraception? ○ *Yes* ○ *No*

When was approximately the date of your last period? .... / .... / ....

4. How would you describe your overall mood on a scale from very negative to very positive

Very negative 1 2 3 4 5 6 7 8 9 10 *Very Positive*

5. How physically energetic are you feeling right now?

Very negative 1 2 3 4 5 6 7 8 9 10 *Very Positive*

6. How mentally alert are you feeling right now?

Foggy/Unfocused 1 2 3 4 5 6 7 8 9 10 *Very Alert*

7. How rested are you feeling?

Very tired 1 2 3 4 5 6 7 8 9 10 *Very rested*

8. How anxious are you feeling?

Relaxed 1 2 3 4 5 6 7 8 9 10 *Very anxious*

9. How many hours did you sleep last night? .... *hours*

10. How many hours ago was your last meal? .... *hours ago*

11. Are you currently experiencing any neurological or health issues (please list)**?**

1. ....

2. ....

3. ....

12. Please check any physical symptoms you are feeling right now:

☐	*Headache*	*Mild*	1	2	3	4	5	*Severe*
☐	*Migraine*	*Mild*	1	2	3	4	5	*Severe*
☐	*Any kind of pain*	*Mild*	1	2	3	4	5	*Severe*
☐	*Nausea*	*Mild*	1	2	3	4	5	*Severe*
☐	*Upset Stomach*	*Mild*	1	2	3	4	5	*Severe*