

Adverse Events

1. Have you experienced any health problem(s) in the past 3 months which you believe is/are related to your participation in the study? (please circle answer)

No (you have now completed this form)

Yes (please complete questions below)

2. Please list health problem(s) below – one per line

(You may list up to three separate health problems below.)

1.
2.
3.

3. Was treatment sought from a health provider for this/these problems? (please circle answer)

No (you have now completed this form)

Yes (please complete questions below)

4. Please select type(s) of health providers and indicate number of visits:

Treatment type	Tick all that apply	Number of visits
General Practitioner (GP)	<input type="checkbox"/>	
Massage therapist	<input type="checkbox"/>	
Occupational therapist	<input type="checkbox"/>	
Optometrist	<input type="checkbox"/>	
Orthotist / Prosthetist	<input type="checkbox"/>	
Podiatrist	<input type="checkbox"/>	
Physiotherapist	<input type="checkbox"/>	
Radiographer / Radiologist	<input type="checkbox"/>	
Sonographer	<input type="checkbox"/>	
Other (please specify)		

The above materials have been developed for use within the Stand Up Victoria study. Any future use of these materials must be referenced to this article.