! Thank you for taking the time to fill out our survey. We are a sickness. Please fill the short survey below to help us gather i nce with motion sickness. It will take 15 minutes to complete ances of winning are no less than 1 in 33 people.	nformation about you and yo	our family's
What is your email? This will be used for raffle prize giveaway, your email will be recorded separate from the rest of the survey so your answers will stay anonymous.		
1. Please state your age.		
2. What is your gender?	MaleFemale	
3. What is your current occupation?		
4. Do you regard yourself as susceptible to motion sickness?	Not at allSlightlyModerately	
A: Your CHILDHOOD Experience	Very much so	
A: Your CHILDHOOD Experience ach of the following types of transport or entertainment ld (before age 12), how often you Travelled or experience Cars	blease indicate: d: Never 1 to 4 trips	
ach of the following types of transport or entertainment ld (before age 12), how often you Travelled or experience	olease indicate: d: Never	
ach of the following types of transport or entertainment ld (before age 12), how often you Travelled or experience	 blease indicate: Never 1 to 4 trips 5 to 10 trips 11+ trips Never 1 to 4 trips 5 to 10 trips 5 to 10 trips 	
ach of the following types of transport or entertainment ld (before age 12), how often you Travelled or experienced Cars Busses or Coaches	 Dease indicate: Never 1 to 4 trips 5 to 10 trips 11+ trips Never 1 to 4 trips 5 to 10 trips 5 to 10 trips 11+ trips 	
ach of the following types of transport or entertainment ld (before age 12), how often you Travelled or experience Cars	 blease indicate: Never 1 to 4 trips 5 to 10 trips 11+ trips Never 1 to 4 trips 5 to 10 trips 5 to 10 trips 	

Aircraft	O Never	
	1 to 4 trips	
	5 to 10 trips	
	11+ trips	
		rese
Small boats	O Never	
	1 to 4 trips	
	 5 to 10 trips 	
	11+ trips	
		rese
Ships e.g. Channel Ferries	O Never	
1 0	1 to 4 trips	
	 5 to 10 trips 	
	 11+ trips 	
		rese
Swings		
Swings	Never	
	1 to 4 trips	
	5 to 10 trips	
	11+ trips	res
Roundabouts: playgrounds	Never	
	1 to 4 trips	
	5 to 10 trips	
	11+ trips	rese
Funfair Rides, Big Dippers	O Never	
	1 to 4 trips	
	5 to 10 trips	
	11+ trips	
		res
ection A: Your CHILDHOOD Experience or each of the following types of transport or entert		
As a child (before age 12), how often you felt sick of		
As a child (before age 12), how often you felt sick oi Cars	O Never	
	NeverRarely	
. As a child (before age 12), how often you felt sick o Cars	O Rarely	
	RarelySometimes	
	RarelySometimesFrequently	rese

Busses or Coaches	Never	
	Rarely	
	Sometimes	
	Frequently	
	 Always 	
Trains	O Never	
	Rarely	
	Sometimes	
	Frequently	
	Always	
Aircraft	O Never	
	Rarely	
	Sometimes	
	Frequently	
	Always	
Small boats	O Never	
	Rarely	
	Sometimes	
	Frequently	
	Always	
Ships e.g. Channel Ferries	O Never	
	O Rarely	
	Sometimes	
	Frequently	
	Always	
Swings	O Never	
	Rarely	
	Sometimes	
	Frequently	
	Always	
	-	
Roundabouts: Playgrounds	O Never	
	O Rarely	
	Sometimes	
	 Frequently 	
	 Always 	
	,	

Eunfair Didos Big Dinnors		
Funfair Rides, Big Dippers	Never	
	Rarely	
	Sometimes	
	Frequently	
	 Always 	
		res
ion A: Your CHILDHOOD Experience each of the following types of transport or enterta ; a child (before age 12), how often you vomited in:	inment please indicate:	
Cars	Never	
	 Rarely 	
	 Frequently 	
	 Always 	
	e , indys	res
Busses or Coaches	Never	
	 Rarely 	
	 Frequently 	
	 Always 	
	C / Wdy5	res
Trains	Never	
	 Rarely 	
	 Sometimes 	
	 Frequently 	
	 Always 	
		res
Aircrafts	O Never	
	 Rarely 	
	 Sometimes 	
	 Frequently 	
	Always	
		res
Small Boats	O Never	
	Rarely	
	Sometimes	
	Frequently	
	FrequentlyAlways	

Ships e.g. Channel Ferries	Never	
	Rarely	
	Sometimes	
	Frequently	
	Always	
	-	reset
Swings	O Never	
	O Rarely	
	Sometimes	
	Frequently	
	 Always 	
		reset
Roundabouts: playgrounds	O Never	
	Rarely	
	Sometimes	
	Frequently	
	Always	
	-	reset
Funfair Rides, Big Dippers	O Never	
	O Rarely	
	Sometimes	
	 Sometimes Frequently 	
	Frequently	
		reset
Section B: Your Experience Over the Last 10 years. For each of the following types of transport or enterta B. Over the Last 10 years (approximately), how often y	 Frequently Always Always 	reset
or each of the following types of transport or enterta	 Frequently Always Always 	reset
or each of the following types of transport or enterta . Over the Last 10 years (approximately), how often y	 Frequently Always Always Always 	reset
or each of the following types of transport or enterta . Over the Last 10 years (approximately), how often y	 Frequently Always Always Inment please indicate: Du Travelled or experienced (tick boxes): Never 	reset
or each of the following types of transport or enterta . Over the Last 10 years (approximately), how often y	 Frequently Always Always Always Du Travelled or experienced (tick boxes): Never 1 to 4 trips 	reset
or each of the following types of transport or enterta . Over the Last 10 years (approximately), how often y	 Frequently Always Always Inment please indicate: Travelled or experienced (tick boxes): Never 1 to 4 trips 5 to 10 trips 	reset
or each of the following types of transport or enterta 8. Over the Last 10 years (approximately), how often y	 Frequently Always Always Inment please indicate: Travelled or experienced (tick boxes): Never 1 to 4 trips 5 to 10 trips 	
or each of the following types of transport or enterta 3. Over the Last 10 years (approximately), how often y Cars	 Frequently Always Always Always Inment please indicate: Du Travelled or experienced (tick boxes): Never 1 to 4 trips 5 to 10 trips 11+ trips 	
or each of the following types of transport or enterta 3. Over the Last 10 years (approximately), how often y Cars	 Frequently Always inment please indicate: Du Travelled or experienced (tick boxes): Never 1 to 4 trips 5 to 10 trips 11+ trips Never	
or each of the following types of transport or enterta . Over the Last 10 years (approximately), how often y Cars	 Frequently Always Always Always Du Travelled or experienced (tick boxes): Never 1 to 4 trips 5 to 10 trips 11+ trips Never 1 to 4 trips 	
or each of the following types of transport or enterta . Over the Last 10 years (approximately), how often y Cars	 Frequently Always inment please indicate: ou Travelled or experienced (tick boxes): Never 1 to 4 trips 5 to 10 trips 11+ trips Never 1 to 4 trips 5 to 10 trips 5 to 10 trips 	
or each of the following types of transport or enterta 3. Over the Last 10 years (approximately), how often y Cars	 Frequently Always inment please indicate: ou Travelled or experienced (tick boxes): Never 1 to 4 trips 5 to 10 trips 11+ trips Never 1 to 4 trips 5 to 10 trips 5 to 10 trips 	reset
or each of the following types of transport or enterta . Over the Last 10 years (approximately), how often y Cars Busses or Coaches	 Frequently Always inment please indicate: ou Travelled or experienced (tick boxes): Never 1 to 4 trips 5 to 10 trips 11+ trips Never 1 to 4 trips 11+ trips 	reset
or each of the following types of transport or enterta Cover the Last 10 years (approximately), how often y Cars Busses or Coaches	 Frequently Always Always Always Inment please indicate: ou Travelled or experienced (tick boxes): Never 1 to 4 trips 5 to 10 trips 11+ trips 5 to 10 trips 11+ trips 11+ trips 10 trips 11+ trips 10 trips 11+ trips 10 trips 11+ trips 10 trips 11+ trips 	reset
For each of the following types of transport or enterta 3. Over the Last 10 years (approximately), how often y Cars Busses or Coaches	 Frequently Always Inment please indicate: ou Travelled or experienced (tick boxes): Never 1 to 4 trips 5 to 10 trips 11+ trips Never 1 to 4 trips 11+ trips 5 to 10 trips 11+ trips 	reset

Aivenatio		
Aircrafts	O Never	
	1 to 4 trips	
	5 to 10 trips	
	11+ trips	res
Small boats	O Never	
	1 to 4 trips	
	5 to 10 trips	
	11+ trips	
		res
Ships e.g. Channel Ferries	O Never	
	1 to 4 trips	
	5 to 10 trips	
	 11+ trips 	
		res
Swings		
отпър	Never	
	 1 to 4 trips 5 to 10 trips 	
	 5 to 10 trips 11 trips 	
	11+ trips	res
Roundabouts: playgrounds	O Never	
	1 to 4 trips	
	5 to 10 trips	
	11+ trips	res
		Tes
Funfair Rides, Big Dippers	O Never	
	1 to 4 trips	
	5 to 10 trips	
	11+ trips	
		res
tion B: Your Experience Over the Last 10 years. each of the following types of transport or entertain		
Over the Last 10 years (approximately), how often you		
Over the Last 10 years (approximately), how often you Cars	O Never	
	NeverRarely	
	O Rarely	
Over the Last 10 years (approximately), how often you Cars	RarelySometimes	res

Busses or Coaches	Never	
	O Rarely	
	Sometimes	
	Frequently	
	 Always 	
		re
Trains	O Never	
	O Rarely	
	Sometimes	
	Frequently	
	Always	
		r
Aircraft	Never	
	O Rarely	
	Sometimes	
	Frequently	
	Always	
Small Boats	Never	
	O Rarely	
	Sometimes	
	Frequently	
	 Always 	
		1
Ships e.g. Channel Ferries	O Never	
	O Rarely	
	Sometimes	
	Frequently	
	 Always 	
		<u> </u>
Swings	Never	
	O Rarely	
	Sometimes	
	Frequently	
	 Always 	
Roundabouts: playgrounds	Never	
	 Rarely 	
	Sometimes	
	Frequently	
	 Always 	
		r

Funfair Rides, Big Dippers	O Never	
	Rarely	
	Sometimes	
	Frequently	
	Always	
	-	reset
ion B: Your Experience Over the Last 10 years.		
each of the following types of transport or entert		
Over the Last 10 years (approximately), how ofter	i you vomited in:	
Cars	Never	
	Rarely	
	Sometimes	
	Frequently	
	Always	
	<i>,</i>	rese
Busses or Coaches	Never	
	Rarely	
	Sometimes	
	Frequently	
	Always	
		rese
Trains	O Never	
	 Rarely 	
	 Sometimes 	
	 Frequently 	
	 Always 	
	- Always	rese
Aircraft	Never	
	Rarely	
	Sometimes	
	Frequently	
	Always	
		rese
Small Boats	O Never	
	RarelySometimes	
	FrequentlyAlways	
	Aiwdys	rese
Ships e.g. Channel Ferries	O Never	
	O Rarely	
	Sometimes	
	Frequently	
	Always	
		rese

Contract		
Swings	Never	
	Rarely	
	Sometimes	
	Frequently	
	Always	
		reset
2		
Roundabouts: playgrounds	Never	
	Rarely	
	Sometimes	
	Frequently	
	Always	
	-	reset
Funfair Rides, Big Dippers	Never	
	Rarely	
	Sometimes	
	Frequently	
	 Always 	
	0 /	reset
11. Does your Mother experience motion sickness?	O Yes	
	No	
	Unknown	
		reset
12. Does your Father experience motion sickness?	O Yes	
	No	
	Unknown	
		reset
13. Does your Grandmother experience motion sickness?	O Yes	
SICKIESS:	O No	
	Unknown	
		reset
14 Deer your Chandfether oversigned metion		
14. Does your Grandfather experience motion sickness?	O Yes	
	No	
	Unknown	
		reset
15a. How many brothers do you have?		
isa. now many brothers ao you have:		
15a. How many of your brothers experience motion sickness?		
15b. How many sisters do you have?		
15b. How many of your sisters experience motion		
sickness?	L	

1. Do you experience dizziness? (If no, skip to question # 9)	NoYes
2. When did you experience your first episode of dizziness? Please write the approximate month and year.	
4. How often do you experience dizziness?	🔘 day
times per: Fill the blank in the next question	week
	month
	🔘 year
	-
4. How often do you experience dizziness? times per (what you chose in the previous	
questions).	
4. What triggered your dizziness?	
5. Choose the most accurate description of your	Room Spinning
dizziness	Feels like you are on a boat
	Lightheaded
	Imbalance
	Problems focusing with
	head movement
5. Choose the 2nd most accurate description of your	Room Spinning
dizziness	Feels like you are on a boat
	Lightheaded
	Problems focusing with
	head movement
5. Choose the 3rd most accurate description of your	Room Spinning
dizziness	O Feels like you are on a boat
	Lightheaded
	O Imbalance
	Problems focusing with
	head movement

5. Choose the 4th most accurate description of your	\bigcirc	Room Spinning	
dizziness		Feels like you are on a boat	
		Lightheaded	
		Imbalance	
		Problems focusing with	
		head movement	
	\cup		reset
Choose the 5th most accurate description of your dizziness.	\bigcirc	Room Spinning	
dizzmess.	\bigcirc	Feels like you are on a boat	
	\bigcirc	Lightheaded	
	\bigcirc	Imbalance	
	\bigcirc	Problems focusing with	
	\bigcirc	head movement	
			reset
How long do your episodes of dizziness typically last?		George	
		Seconds	
		Minutes	
		Hours	
		Days	
	\bigcirc	Weeks	reset
Be specific about the previous questions with a			
numeric number. For example, if your episodes last 10 seconds, choose seconds in the previous question and			
write 10 here.			
7. Did your dizziness start after head trauma or brain	\bigcirc	Yes	
surgery?	\bigcirc	No	
			reset
8. Do you have dizziness when you look up?	\bigcirc	Yes	
	\bigcirc	No	reset
			reset
9. Do you experience motion sickness?	\bigcirc	Yes	
	\bigcirc	No	
			reset
	_		
9a. Did you ever experience motion sickness as a passenger in a car including childhood?	\bigcirc	Yes	
	\bigcirc	No	reset
			reset
9b. Do you experience dizziness or headaches when	\bigcirc	Yes	
watching 3-D movies?	\bigcirc	No	
			reset
	~		
10. Have you ever experienced head/ brain fog (i.e. feelings of mental confusion or lack of mental		Yes	
clarity)?	\bigcirc	No	reset
			i CoCl

11. Do you experience dizziness with headaches?	AlwaysSometimesNever	
12. Have you suffered from headaches in the past	O Yes	reset
year?	O No	reset
13. When did you experience your first headache episode? Please write an approximate month and year.		
14. How often do you experience headaches? X times per:	dayweek	
	monthyear	reset
14. Please estimate the amount of X in the previous question:		
15. How long do your headaches typically last?:	 seconds minutes hours days weeks 	reset
15. Please fill in the blank in the previous question. For example, if you have 10 minute headaches, write 10 here and choose headaches in the previous question.		
16. How would you describe the pain of the headaches?	mildmoderate	
	 severe 	reset
17. Did your headache start after head trauma or brain surgery?	YesNo	reset
18. Do your headaches get worse with Menstrual periods?	YesNoNot applicable	reset
18. Do your headaches get worse with birth control?	NoYesnot applicable	
		reset

18. Do your headaches get worse with certain food?	O Yes	
	O No	
		re
18. Do your headaches get worse with sleep	O Yes	
disturbances?	 Yes No 	
	∪ NO	re
18. Do your headaches get worse with physical activity?	O Yes	
, .	O No	re
18. Do your headaches get worse with Bowel	O Yes	
movements (e.g. diarrhea or constipation)	O No	
		re
19. Where is the headache located? (check all that	Right side	
apply):	Left side	
	Forehead	
	Temple	
	Back	
	Dack	
20. Have you experienced neck stiffness?	0	
20. nave you experienced neck stimless:	• Yes	
	O No	re
21. Do you experience ear pain? If so where.	O Right	
	○ Left	
	O Both	
	O No	
		re
22. Have you ever experienced recurrent sinus	O Yes	
headaches?	O No	
		re
22. Usive you ever every sign and iss groups had a bee	<u> </u>	
23. Have you ever experienced ice cream headaches (i.e. brain-freeze)?	O Yes	
	O No	re
24. Has wind or air conditioning ever caused you sinus	O Yes	
pain, facial pressure, or headache?	O No	
		re
25. Do you find relief of your headaches with	O Yes	
medications?	 Yes No 	
	UNU VINU	re
26. Do your headaches reduce your productivity at work or school?	O Yes	
	O No	
		re

27. Do your headaches interfere with your daily life activities (e.g. chores at home)?	YesNo	
28. Have you ever been prescribed medication for	O Yes	
migraine?	O No	
29. Do you experience Pulsating or throbbing pain	Before	
before/during/after your headaches? Check all that	During	
apply.	After	
	_	
	Not applicable	
29. Do you experience Visual loss, black spots or	Before	
flashing lights lasting at least 15 min		
before/during/after your headaches? Check all that	During	
apply.	After	
	Not applicable	
29. Do you experience weakness before/during/after	Before	
your headaches? Check all that apply.		
	 During After 	
	Not applicable	
29. Do you experience difficulty speaking	Before	
before/during/after your headaches? Check all that	During	
apply.	After	
	Not applicable	
29. Do you experience nausea before/during/after	Before	
your headaches? Check all that apply.	During	
	After	
	Not applicable	
29. Do you experience vomiting before/during/after	Before	
your headaches? Check all that apply.	During	
	After	
	Not applicable	
29. Do you experience sensitivity to light	Before	
before/during/after your headaches? Check all that apply.	During	
	After	
	Not applicable	

29. Do you experience Sensitivity to sounds before/during/after your headaches? Check all that apply.	BeforeDuring
	AfterNot applicable
29. Do you experience Drowsiness before/during/after	Before
your headaches? Check all that apply.	During
	After
	Not applicable
29. Do you experience Unsteadiness	Before
before/during/after your headaches? Check all that apply.	During
	After
	Not applicable
29. Do you experience lightheadedness	Before
before/during/after your headaches? Check all that apply.	During
	After
	Not applicable
29. Do you Feel like you are on a boat	Before
before/during/after your headaches? Check all that apply.	During
	After
	Not applicable
29. Do you experience feeling "off"	Before
before/during/after your headaches? Check all that apply.	During
	After
	Not applicable
30. Do you ever experience pain with light touch on	O Yes
your scalp or face?	O No
31. Have you ever had your balance system tested?	O Yes
(ie. ENG, VNG, etc.)	No
32. Have you ever been told that you have:	Migraines
	Irritable Bowel Syndrome I
	Meniere's Disease
	Benign positional vertigo
	Gluten Hypersensitivity
	Celiac Disease

33. Does anyone in your immediate family have a	Migraines
history of:	Meniere's Disease
	Motion Sickness
34. Do you have dizziness when you are:	
check all that apply.	Lying down
	Sitting up
	Standing up
	Turning your head
	Walking
	Hearing loud noises
	In a car or moving vehicle
	Walking in a supermarket aisle
	Motion
	Medication
	Not applicable
35. Are you sensitive to any of the following? (check	Lights
all that apply):	 Weather changes
	Smells
	Excess motion on TV or computer
	Excess motion in a movie theater
	Sounds
	Not applicable
36.Do you experience Sensation of objects moving	Before
around you before, during, or after your dizziness episodes? Check all that apply.	During
channel and an out off de	After
	Not appicable
36.Do you experience Spinning sensation when	
stationary before, during, or after your dizziness	Before
episodes? Check all that apply	During
	After
	Not applicable
36.Do you experience Ear pressure or fullness (not	Before
relieved by popping your ears) before, during, or after	During
your dizziness episodes? Check all that apply.	After
	Not applicable
36.Do you experience Ringing or buzzing in your ears	Before
before, during, or after your dizziness episodes? Check all that apply.	During
succean class apply.	After
	Not applicable

36.Do you experience Pulsing sound in your ears before, during, or after your dizziness episodes? Check all that apply.	 Before During After Not applicable
36.Do you experience Hearing loss before, during, or after your dizziness episodes? Check all that apply.	 Before During After Not applicable
36.Do you experience Nausea/ Vomiting before, during, or after your dizziness episodes? Check all that apply.	 Before During After Not applicable
36.Do you experience Fatigue before, during, or after your dizziness episodes? Check all that apply.	 Before During After Not applicable
36.Do you experience Unsteadiness/ Imbalance before, during, or after your dizziness episodes? Check all that apply.	 Before During After Not applicable
36.Do you experience Headache before, during, or after your dizziness episodes? Check all that apply.	 Before During After Not applicable
36.Do you experience Anxiety before, during, or after your dizziness episodes? Check all that apply.	 Before During After Not applicable
37. If you experienced any of the above symptoms, how long did they last?	 Minutes Hours Days Weeks Not applicable
Submit	