SUPPLEMENTARY FILES:

Supplementary File 1: Case report forms

Baseline Demographics

*=HEAL required questions

1. 1. *Gender identity ☐ Male ☐ Female ☐ Unknown Other, Specify: ____________

2. *What is the highest level of education you have completed?
   - ☐ Did not complete Secondary School or Less than High School
   - ☐ Some Secondary School or High School Education
   - ☐ High School or Secondary School Degree Complete
   - ☐ Associate’s or Technical Degree Complete
   - ☐ Doctoral or Postgraduate Education

3. *What is your current employment status?
   - ☐ Full-time employment
   - ☐ Not employed
   - ☐ Part-time employment

4. *What category best describes your current relationship status?
   - ☐ Divorced
   - ☐ Married
   - ☐ Never Married
   - ☐ Separated
   - ☐ Widowed
   - ☐ Domestic Partner

5. Including yourself, how many people live in your household? _________

6. *How long have you had the type of pain for which you are enrolled in this study? (Please list the number of months) __________

7. Is your low back pain more severe than pain in other parts of your body?
   a) Yes
   b) No
   c) Not sure

8. Have you ever had a low-back operation?
   a) Yes, one operation
   b) Yes, more than one operation
   c) No

9. If yes, when was your last back operation?
   a) Less than 6 months
   b) More than 6 months but less than 1 year ago
   c) Between 1 and 2 years ago
   d) More than 2 years ago

10. Did any of your back operations involve a spinal fusion? (also called an arthrodesis?)
    a) Yes
    b) No
    c) Not sure

11. Have you been off work or unemployed for 1 month or more due to low-backpain?
    a) Yes
    b) No
    c) Does not apply

12. Have you filed or been awarded a worker's compensation claim related to your back problem?
    a) Yes
    b) No
    c) Does not apply

13. Are you involved in a lawsuit or legal claim related to your back problem?
    a) Yes
    b) No
    c) Not sure

14. *Have you ever applied for, or received, disability insurance for your pain condition?
    a) Yes
    b) No

15. *What is your annual household income from all sources?
    - ☐ Less than $10,000
    - ☐ $10,000 - $24,000
    - ☐ $25,000 - $34,999
    - ☐ $35,000 - $49,999
    - ☐ $50,000 - $74,999
    - ☐ $75,000 - $99,999
    - ☐ $100,000 - $149,999
    - ☐ $150,000 - $199,999
    - ☐ $200,000 or more
    - ☐ Prefer not to answer

Minimum Dataset: Outcomes Assessment

Completed at baseline and 3 months

*=HEAL-required CDE

Pain Duration and Frequency

1. How long has low-back pain been an ongoing problem for you?
    a) <3 months
    b) 3-6 months
    c) 6 months-1 year
    d) 1 to 5 years
    e) More than 5 years

2. How often has low-back pain been an ongoing problem for you over the past 6 months?
    a) Every day or nearly every day in the past 6 months
    b) At least half the days in the past 6 months
    c) Less than half the days in the past 6 months

Pain Location

3. Has back pain spread to your buttock or thigh during the past 2 weeks?
    a) Yes
    b) No
    c) Not sure

4. Has back pain spread below your knee during the past 2 weeks?
    a) Yes
    b) No
    c) Not sure

Widespread Pain

5. Do you have chronic pain the following areas?
    a) Head or face (Yes/No)
    b) Right hand, arm, or shoulder (Yes/No)
    c) Left hand, arm, or shoulder (Yes/No)
    d) Right buttock, leg, or foot (Yes/No)
    e) Left buttock, leg, or foot (Yes/No)
    f) Chest, abdomen, or pelvis (Yes/No)
    g) Neck or upper back (Yes/No)

Pain Somatization

6. During the past 4 weeks, how much have you been bothered by…
   a) Stomach pain
   b) Not bothered at all
   c) Bothered a little
   d) Bothered a lot
   e) Headaches
   f) Not bothered at all
   g) Bothered a little
   h) Bothered a lot

Low-Back Pain Specific Pain Intensity

7. How would you rate your ***low-back pain*** on average?
   _0_1_2_3_4_5_6_7_8_9_10
   No Pain Worst imaginable pain

Current Opioid Use

8. Are you currently taking any opioid medications on a daily basis? (*Opioid or narcotic medications include prescription medications such as Vicodin, Lortab, Narco, Hydrocodone, codeine, Tylenol #3 or #4, Fentanyl, Duragesic, MS Contin, Percocet, OxyContin, oxycodone, Morphine, methadone, tramadol, Ultram, Diluadid)*
   a) Yes
   b) Not
   c) Not Sure

Sleep Duration*

1. During the past month, how many hours and minutes of actual sleep did you get at night? (This may be different than the number of hours and minutes you spent in bed)

   ___ hours and ___ minutes of sleep per night

Pain Intensity Journal (7 days)

Rate your average [back] pain today on a scale from 0-10, where 0 means no pain and 10 means the worst pain imaginable.

_0_1_2_3_4_5_6_7_8_9_10
No Pain Worst imaginable pain

Motion Sickness Propensity Questionnaire

1. I am susceptible to sickness induced by video or computer games.
    a) True
    b) False

2. I get motion sickness.
    a) True
    b) False

Immersive Tendency Questionnaire

Source: Witmer, B. G., & Singer, M. J. (1998). Measuring presence in virtual environments: A presence questionnaire. *Presence*, *7*(3), 225-240.

1. Do you ever get extremely involved in projects that are assigned to you by your boss or your instructor, to the exclusion of other tasks?
   ___1___2___3___4___5___6___7
   Never Occasionally Often

2. How easily can you switch your attention from the task in which you are currently involved to a new task?
   ___1___2___3___4___5___6___7
   Not so easily Fairly Often

3. How frequently do you get emotionally involved (angry, sad, or happy) in the news stories that you read or heart?
   ___1___2___3___4___5___6___7
   Never Occasionally Often

4. How well do you feel today?
   ___1___2___3___4___5___6___7
   Not well Pretty well Excellent

5. Do you easily become deeply involved in movies or TV dramas?
   ___1___2___3___4___5___6___7
   Never Occasionally Often

6. Do you ever become so involved in a television program or book that people have problems getting your attention?
   ___1___2___3___4___5___6___7
   Never Occasionally Often

7. How mentally alert do you feel at the present time?
   ___1___2___3___4___5___6___7
   Not alert Moderately Alert Fully Alert

8. Do you ever become so involved in a television program or book that people have problems getting your attention?
   ___1___2___3___4___5___6___7
   Never Occasionally Often

9. How frequently do you find yourself closely identifying with the characters in a story line?
   ___1___2___3___4___5___6___7

Never Occasionally Often

10. Do you ever become so involved in a video game that it is as if you are inside the game rather than moving a joystick and watching the screen?
___1___2___3___4___5___6___7
Never Occasionally Often

11. On average, how many books do you read for enjoyment in a month?
___1___2___3___4___5___6___7

12. What kind of books do you read most frequently?
1, Spy novels | 2, Adventure novels | 3, Westerns | 4, Biographies | 5, Fantasies | 6, Romance novels | 7, Mysteries | 8, Autobiographies | 9, Science fiction | 10, Historical novels | 11, Other fiction | 12, Other non-fiction

13. How physically fit do you feel today?
___1___2___3___4___5___6___7
Not fit Moderately fit Extremely fit

14. How good are you at blocking out external distractions when you are involved in something?
___1___2___3___4___5___6___7
Not very good Somewhat good Very good

15. When watching sports, do you ever become so involved in the game that you react as if you were one of the players?
___1___2___3___4___5___6___7
Never Occasionally Often

16. Do you ever become so involved in a daydream that you are not aware of things happening around you?
___1___2___3___4___5___6___7
Never Occasionally Often

17. Do you ever have dreams that are so real that you feel disoriented when you awake?
___1___2___3___4___5___6___7
Never Occasionally Often

18. When playing sports, do you become so involved in the game that you lose track of time?
___1___2___3___4___5___6___7
Never Occasionally Often

19. Are you easily disturbed when working on a task?
___1___2___3___4___5___6___7
Never Occasionally Often

20. How well do you concentrate on enjoyable activities?
    ___1___2___3___4___5___6___7
    Never Occasionally Often

21. How often do you play arcade or video games? (FOTEN should be taken to mean every day or every two days, on average.)
    ___1___2___3___4___5___6___7
    Never Occasionally Often

22. How well do you concentrate on disagreeable tasks?
    ___1___2___3___4___5___6___7
    Not well Moderately well Very well

23. Have you ever gotten excited during a chase or fight scene on TV or in the movies?
    ___1___2___3___4___5___6___7
    Never Occasionally Often

24. To what extent have you dwelled on personal problems in the last 48 hours?
    ___1___2___3___4___5___6___7
    Never Occasionally Often

25. Have you ever gotten scared by something happening on a TV show or in a movie?
    ___1___2___3___4___5___6___7
    Never Occasionally Often

26. Have you ever remained apprehensive or fearful long after watching a scary movie?
    ___1___2___3___4___5___6___7
    Never Occasionally Often

27. Do you ever avoid carnival or fairground rides because they are too scary?
    ___1___2___3___4___5___6___7
    Never Occasionally Often

28. How frequently do you watch TV soap operas or docu-dramas?
    ___1___2___3___4___5___6___7
    Never Occasionally Often

29. Do you ever become so involve din doing something that you lose all track of time?
    ___1___2___3___4___5___6___7
    Never Occasionally Often

Simulator Sickness Questionnaire

Kennedity, Lane, Berbaym, & Lilienthal (1993)***

Source: Original Version – Kennedy, R.S., Lane, N.E., Berbaum, K.S., & Lilienthal, M.G. (1993). Simulator Sickness Questionnaire: An enhanced method for quantifying simulator sickness. International Journal of Aviation Psychology, *3*(3), 203-220. Last version: March 2013

Instructions: Circle how much each symptom below is affecting you right now.

1.	General discomfort	None	Slight	Moderate	Severe
2.	Fatigue	None	Slight	Moderate	Severe
3.	Headache	None	Slight	Moderate	Severe
4.	Eye strain	None	Slight	Moderate	Severe
5.	Difficulty focusing	None	Slight	Moderate	Severe
6.	Salivation increasing	None	Slight	Moderate	Severe
7.	Sweating	None	Slight	Moderate	Severe
8.	Nausea	None	Slight	Moderate	Severe
9.	Difficulty concentrating	None	Slight	Moderate	Severe
10.	<< Fullness of the head >>	None	Slight	Moderate	Severe
11.	Blurred vision	None	Slight	Moderate	Severe
12.	Dizziness with eyes open	None	Slight	Moderate	Severe
13.	Dizziness with eyes closed	None	Slight	Moderate	Severe
14.	*Vertigo	None	Slight	Moderate	Severe
15.	**Stomach awareness	None	Slight	Moderate	Severe
16.	Burping	None	Slight	Moderate	Severe

* Vertigo is experience as loss of orientation with respect to vertical upright.

** Stomach awareness is usually used to indicate a feeling of discomfort which is just short of nausea.

Presence Scale Questionnaire

On a five-point scale (1 = not at all; 5 = extremely), designate the degree to which you feel presence.

1. To what extent did you feel like you were inside the virtual world?
   ___1___2___3___4___5
   Not at all Extremely

2. To what extent did you feel immersed in the virtual world?
   ___1___2___3___4___5
   Not at all Extremely

3. To what extent did you feel surrounded by the virtual world you saw and heard?
   ___1___2___3___4___5
   Not at all Extremely

4. How much did it feel as if you visited another place?
   ___1___2___3___4___5
   Not at all Extremely

5. How much was the virtual world like the real world?
   ___1___2___3___4___5
   Not at all Extremely

6. To what extent were you distracted by noises in the physical world while you were inside the virtual world?
   ___1___2___3___4___5

   Not at all Extremely

PROMIS Pain Interference – Short Form 8a

PROMIS® Item Bank v1.0 – Pain Interference – Short Form 8a

Pain Interference – Short Form 8a

Please respond to each question or statement by marking one box per row.

In the past 7 days…

		Not at all	A little bit	Somewhat	Quite a bit	Very much
PAININ9	How much did pain interfere with your day to day activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ22	How much did pain interfere with work around the home?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ31	How much did pain interfere with your ability to participate in social activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ34	How much did pain interfere with your household chores?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ12	How much did pain interfere with the things you usually do for fun?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ36	How much did pain interfere with your enjoyment of social activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ3	How much did pain interfere with your enjoyment of life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ13	How much did pain interfere with your family life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

PROMIS Physical Function– Short Form 6b

PROMIS® Item Bank v2.0 – Physical Function – Short Form 6b

Physical Function – Short Form 6b

Please respond to each question or statement by marking one box per row.

		Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
PFA11	Are you able to do chores such as vacuuming or yard work?..........................	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA21	Are you able to go up and down stairs at a normal pace?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA23	Are you able to go for a walk of at least 15 minutes?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA53	Are you able to run errands and shop?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		Not at all	**Very little**	**Somewhat**	**Quite a lot**	**Cannot do**
PFC12	Does your health now limit you in doing two hours of physical labor?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFB1	Does your health now limit you in doing moderate work around the house like vacuuming, sweeping floors or carrying in groceries?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

PROMIS Emotional Distress Anxiety – Short Form 4a

PROMIS Item Bank v1.0-Emotional Distress-Anxiety – Short Form 4a

Emotional Distress-Anxiety – Short Form 4a

Please respond to each question or statement by marking one box per row.

In the past 7 days…

		Never	Rarely	Sometimes	Often	Always
EDANX01	I felt fearful	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX40	I found it hard to focus on anything other than my anxiety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX41	My worries overwhelmed me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX53	I felt uneasy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

PROMIS Depression – 4-item

In the past 7 days...	Never	Rarely	Sometimes	Often	Always
I felt worthless					
I felt helpless					
I felt depressed					
I felt hopeless					

PROMIS Sleep Disturbance – Short Form 6a

PROMIS Item Bank v1.0 – Sleep Disturbance – Short Form 6a

Sleep Disturbance – Short Form 6a

Please respond to each question or statement by marking one box per row.

	In the past 7 days…	**Very poor**	**Poor**	**Fair**	**Good**	**Very good**
Sleep109	My sleep quality was	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
	In the past 7 days…	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
Sleep116	My sleep was refreshing........................	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Sleep20	I had a problem with my sleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sleep44	I had difficulty falling asleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sleep108	My sleep was restless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sleep72	I tried hard to get to sleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

PEG – Pain Screening Tool

Select the one number that describes your pain.

1) What number best describes your pain on average in the past week?

__0 __1 __2 __3 __4 __5 __6 __7 __8 __9 __10

No Pain | Pain as bad as you can imagine

2) What number best describes how, during the past week, pain has interfered with your enjoyment oflife?

__0 _1 _2 _3 _4 _5 _6 _7 _8 _9 10

Does not Interferes Interfere | Completely

3) What number best describes how, during the past week, pain has interfered with your general activity?

__0 _1 _2 _3 _4 _5 _6 _7 _8 _9 10

Does not Interferes Interfere | Completely

Pain Catastrophizing Questionnaire – Short Form 6-item

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are six statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

When I'm in pain …

1. It's awful and I feel that it overwhelms me

__0	1	2	3	4
Not at all	To a slight degree	To a moderate degree	To a great degree	All the time

2. I feel I can't stand it anymore

____0	1	2	3	4
Not at all	To a slight degree	To a moderate degree	To a great degree	All the time

3. I become afraid that the pain will get worse

____0	1	2	3	4
Not at all	To a slight degree	To a moderate degree	To a great degree	All the time

4. I keep thinking about how much it hurts

____0	1	2	3	4
Not at all	To a slight degree	To a moderate degree	To a great degree	All the time

5. I keep thinking about how badly I want the pain to stop

____0	1	2	3	4
Not at all	To a slight degree	To a moderate degree	To a great degree	All the time

6. I wonder whether something serious may happen

____0	1	2	3	4
Not at all	To a slight degree	To a moderate degree	To a great degree	All the time

Pain Health Questionnaire – 2 (PHQ-2)

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things

___0	___1	___2	___3
Not at all	Several days	More than half the days	Nearly every day

2. Feeling down, depressed, or hopeless

___0	___1	___2	___3
Not at all	Several days	More than half the days	Nearly every day

Generalized Anxiety Disorder-2 (GAD-2)

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Feeling nervous, anxious, or on edge

___0	___1	___2	___3
Not at all	Several days	More than half the days	Nearly every day

2. Not being able to stop or control worrying

___0	___1	___2	___3
Not at all	Several days	More than half the days	Nearly every day

Patient Global Impression of Change (PGIC)

Since the start of intervention, my overall pain is ….

__1 – Very much improved

__2 – Much improved

__3 – Minimally improved

__4 – No Change

__5 – Minimally worse

__6 – Much worse

__7 – Very much worse

Event Assessment

Day 1:

1. Have you experienced anything different during or after use of the VR headset?
    a. Yes
    b. No
    c. Other

2. If Yes or Other, please describe the event. A research staff member will follow-up up with you about this event as soon as possible.
    - [Open Text Box]

15-day interval, end of study:

3. During the past 14 days, have you experienced anything different during or after use of the VR headset?
    a. Yes
    b. No
    c. Other

4. If Yes or Other, please describe the event. A research staff member will follow-up up with you about this event as soon as possible.
    - [Open Text Box]

Custom Questions

Screener Week

1. Have you experienced virtual reality before?
    a. Yes
    b. No

End of study survey

2. Would you have wanted to continue to use the device?
    a. Yes
    b. No

TAPS Tool Part 1

NIDA Clinical Trials Network
The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

TAPS Tool Part 1

Web Version: 2.0; 4.00; 09-19-17

General Instructions:
The TAPS Tool Part 1 is a 4-item screening for tobacco use, alcohol use, prescription medication misuse, and illicit substance use in the past year. Question 2 should be answered only by males and Question 3 only be females. Each of the four multiple-choice items has five possible responses to choose from. Check the box to select your answer.

Segment:
Visit number:

1. In the PAST 12 MONTHS, how often have you used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes, or smokeless tobacco)?

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

2. In the PAST 12 MONTHS, how often have you had 5 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by males).

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

3. In the PAST 12 MONTHS, how often have you had 4 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by females).

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

4. In the PAST 12 MONTHS, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

5. In the PAST 12 MONTHS, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you? Prescription medications that may be used this way include: Opiate pain relievers (for example, OxyContin, Vicodin, Percocet, Methadone) Medications for anxiety or sleeping (for example, Xanax, Ativan, Klonopin) Medications for ADHD(for example, Adderall or Ritalin)

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

TAPS Tool Part 2

NIDA Clinical Trials Network
The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

TAPS Tool Part 2

Web Version: 2.0; 4.00; 09-19-17

General Instructions:
The TAPS Tool Part 2 is a brief assessment for tobacco, alcohol, and illicit substance use and prescription medication misuse in the PAST 3 MONTHS ONLY. Each of the following questions and sub-questions has two possible answer choices- either yes or no. Check the box to select your answer.

1. In the PAST 3 MONTHS, did you smoke a cigarette containing tobacco? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you usually smoke more than 10 cigarettes each day? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, did you usually smoke within 30 minutes after waking? ☐ Yes ☐ No

2. In the PAST 3 MONTHS, did you have a drink containing alcohol? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you have 4 or more drinks containing alcohol in a day?* (Note: This question should only be answered by females). ☐ Yes ☐ No

b. In the PAST 3 MONTHS, did you have 5 or more drinks containing alcohol in a day?* (Note: This question should only be answered by males). ☐ Yes ☐ No

*One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.

c. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop drinking? ☐ Yes ☐ No

d. In the PAST 3 MONTHS, has anyone expressed concern about your drinking? ☐ Yes ☐ No

3. In the PAST 3 MONTHS, did you use marijuana (hash, weed)? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you had a strong desire or urge to use marijuana at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of marijuana? ☐ Yes ☐ No

4. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth)? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth) at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of cocaine, crack, or methamphetamine (crystal meth)? ☐ Yes ☐ No

5. In the PAST 3 MONTHS, did you use heroin? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using heroin? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of heroin? ☐ Yes ☐ No

6. In the PAST 3 MONTHS, did you use a prescription opiate pain reliever (for example, Percocet, Vicodin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using an opiate pain reliever? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of an opiate pain reliever? ☐ Yes ☐ No

7. In the PAST 3 MONTHS, did you use a medication for anxiety or sleep (for example, Xanax, Ativan, or Klonopin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you had a strong desire or urge to use medications for anxiety or sleep at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of medication for anxiety or sleep? ☐ Yes ☐ No

8. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of a medication for ADHD (for example, Adderall or Ritalin)? ☐ Yes ☐ No

9. In the PAST 3 MONTHS, did you use any other illegal or recreational drug (for example, ecstasy/molly, GHB, poppers, LSD, mushrooms, special K, bath salts, synthetic marijuana ('spice'), whip-its, etc.)? ☐ Yes ☐ No

If "Yes", answer the following questions:

In the PAST 3 MONTHS, what were the other drug(s) you used?

Comments:

Discontinuation of Treatment Questionnaire

1. In the last week, how many days did you use the VR headset?
   a. None of the days
   b. Some of the days
   c. Most of the days
   d. All of the days

2. Which of the following best describes why you have not used the VR headset in the last week?

   Technical problem(s) using the headset
   a. Yes
   b. No

   Unsatisfied with the program content

   a. Yes
   b. No

   VR headset is uncomfortable

   a. Yes
   b. No

   Schedule too busy to use the headset

   a. Yes
   b. No

   Pain is too high to use the headset

   a. Yes
   b. No

   The program does not relieve my pain

   a. Yes
   b. No

   Other [open text box]

3. Would it be ok for a study team member to call you and help resolve any problems with the headset?
   a. Yes
   b. No

Perceived Study Arm Question

This VR study involved randomly assigning all study participants to receive one of the following:
(1) *active VR treatment for chronic pain* or
(2) an intervention that did *not* include active VR treatment for chronic pain.

Your amazon code email that you get after returning the equipment will tell you the group you were in. Before we tell you, we would like you to guess your group assignment.

I believe that I received:

1. (1) *active VR treatment for chronic pain.*
2. (2) an intervention that did *not* include active VR treatment for chronic pain.

Treatment Expectation Question

1. I believe this treatment will help me…
   a. Not at all
   b. A little bit
   c. Somewhat
   d. Quite a bit
   e. Very much

End of study procedure Question

Since the beginning of the study, have you had any of the following procedures/treatments? (Select all that apply)

- Injections (TFESI, SNRB, ESI, Facet Block, steroid, facet joints, sacroiliac joint injections, Epidural injections, Rhizotomy, inter laminar or transforaminal injection)
- Pain Pump
- Occupational Therapy, Physical Therapy
- Aqua Therapy
- Acupuncture/acupressure
- Chiropractic procedures (adjustments)
- Massage
- TENS unit
- Radio frequency ablations (RFA)
- Cannabis related products
- Other [open text box]