

Participant Number

Date

--

[illegible]

Are you presently experiencing any feelings of anxiety?

Yes

No

If Yes, please indicate the level of anxiety using the scale below

[illegible]

**Were there any sounds on the recording that caused you to feel discomfort?
(Example: heard discomfort, caused anxiety, felt dizzy, etc.)**

Yes

No

If Yes, please indicate which sounds.

What sounds during the listening session did you find pleasing?

Did you notice changes in your breathing while listening?

Yes

No

Did you experience any emotional sensation as you listened to the recording?

Yes

No

If Yes, please indicate the emotion experienced

Did you experience any physical sensation as you listened to the recording?

Yes

No

If Yes, please indicate the physical sensation experienced

[illegible]

While listening, did you experience moments that brought particular images or pictures to mind?

Yes

No

If Yes, briefly describe your most vivid example.

What type of environmental sound(s) do you find pleasing?

Did you find the duration of the recording to be:

Short

Just right

Too Long

Do you listen to music for calming effects? If so, please briefly describe the type of music you listen to and the setting (example: headphones while sitting, speakers in my bedroom, etc.)