

Experience #1: _____ (Write Down The Name Of The Emotion)		Experience #2: _____ (Write Down The Name Of The Emotion)	
VISUAL		VISUAL	
<input type="checkbox"/> Close	<input type="checkbox"/> Far Away	<input type="checkbox"/> Close	<input type="checkbox"/> Far Away
<input type="checkbox"/> Bright	<input type="checkbox"/> Dark	<input type="checkbox"/> Bright	<input type="checkbox"/> Dark
<input type="checkbox"/> Associated	<input type="checkbox"/> Disassociated	<input type="checkbox"/> Associated	<input type="checkbox"/> Disassociated
<input type="checkbox"/> Color	<input type="checkbox"/> Black and White	<input type="checkbox"/> Color	<input type="checkbox"/> Black and White
<input type="checkbox"/> 3D	<input type="checkbox"/> 2D	<input type="checkbox"/> 3D	<input type="checkbox"/> 2D
<input type="checkbox"/> Moving	<input type="checkbox"/> Still	<input type="checkbox"/> Moving	<input type="checkbox"/> Still
<input type="checkbox"/> Fast	<input type="checkbox"/> Slow	<input type="checkbox"/> Fast	<input type="checkbox"/> Slow
Location <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Top <input type="checkbox"/> Bottom <input type="checkbox"/> Center		Location <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Top <input type="checkbox"/> Bottom <input type="checkbox"/> Center	
<input type="checkbox"/> Clear	<input type="checkbox"/> Hazy	<input type="checkbox"/> Clear	<input type="checkbox"/> Hazy
<input type="checkbox"/> Foreground	<input type="checkbox"/> Background	<input type="checkbox"/> Foreground	<input type="checkbox"/> Background
AUDITORY		AUDITORY	
<input type="checkbox"/> Close	<input type="checkbox"/> Far Away	<input type="checkbox"/> Close	<input type="checkbox"/> Far Away
<input type="checkbox"/> Loud	<input type="checkbox"/> Soft	<input type="checkbox"/> Loud	<input type="checkbox"/> Soft
<input type="checkbox"/> Internal	<input type="checkbox"/> External	<input type="checkbox"/> Internal	<input type="checkbox"/> External
<input type="checkbox"/> High Pitch	<input type="checkbox"/> Low Pitch	<input type="checkbox"/> High Pitch	<input type="checkbox"/> Low Pitch
<input type="checkbox"/> Surround	<input type="checkbox"/> Mono	<input type="checkbox"/> Surround	<input type="checkbox"/> Mono
<input type="checkbox"/> Moving	<input type="checkbox"/> Still	<input type="checkbox"/> Moving	<input type="checkbox"/> Still
<input type="checkbox"/> Fast	<input type="checkbox"/> Slow	<input type="checkbox"/> Fast	<input type="checkbox"/> Slow
Direction <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Top <input type="checkbox"/> Bottom <input type="checkbox"/> Front <input type="checkbox"/> Behind		Direction <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Top <input type="checkbox"/> Bottom <input type="checkbox"/> Front <input type="checkbox"/> Behind	
<input type="checkbox"/> Clear	<input type="checkbox"/> Muffled	<input type="checkbox"/> Clear	<input type="checkbox"/> Muffled
<input type="checkbox"/> Foreground	<input type="checkbox"/> Background	<input type="checkbox"/> Foreground	<input type="checkbox"/> Background
Phrase Associated		Phrase Associated	
KINESTHETIC		KINESTHETIC	
Location In Body		Location In Body	
Direction Of Movement <input type="checkbox"/> Clockwise <input type="checkbox"/> Anti-Clockwise <input type="checkbox"/> Forward Cycling <input type="checkbox"/> Backward Cycling		Direction Of Movement <input type="checkbox"/> Clockwise <input type="checkbox"/> Anti-Clockwise <input type="checkbox"/> Forward Cycling <input type="checkbox"/> Backward Cycling	
Shape		Shape	
Level of intensity 0 1 2 3 4 5 6 7 8 9 10		Level of intensity 0 1 2 3 4 5 6 7 8 9 10	