General anxiety and fiber intake survey

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Our goal is to better understand and investigate the relationship between dietary intake and mental health. We are especially interested in finding out if low fiber intake is linked to anxiety symptoms in general. Certain questions might be hard to answer. Try to always provide an answer. Thank you for your time and involvement.

# Section A. Dietary intake

Please report your dietary intake in frequencies (select only one) over the past month:

1. Over the past month, how often did you eat **fresh fruit** (such as apples, oranges, or berries)?

○ 1 time or less in the past month

○ 2-3 times in the past month

○ 1 time per week

○ 2 times per week

○ 3-4 times per week

○ 5-6 times per week

○ 1 time per day

○ 2 or more times per day

1. Over the past month, how often did you eat **avocado** or **guacamole**?

○ 1 time or less in the past month

○ 2-3 times in the past month

○ 1 time per week

○ 2 times per week

○ 3-4 times per week

○ 5-6 times per week

○ 1 time per day

○ 2 or more times per day

1. Over the past month, how much of the time eating did you eat **cooked** vegetables/greens (such as potato, asparagus, turnip, carrots, or kale)?

○ Almost never or never

○ About 1⁄4 of the time

○ About 1⁄2 of the time

○ About 3⁄4 of the time

○ Almost always or always

1. Over the past month, how much of the time eating did you eat **raw** vegetables/greens (such as carrots, lettuce, tomato, or cucumber)?

○ Almost never or never

○ About 1⁄4 of the time

○ About 1⁄2 of the time

○ About 3⁄4 of the time

○ Almost always or always

1. Over the past month, how much of the time eating did you eat whole **grain** foods (such as whole oats, whole wheat, buckwheat, quinoa, brown rice, popcorn, whole grain bread)?

○ Almost never or never

○ About 1⁄4 of the time

○ About 1⁄2 of the time

○ About 3⁄4 of the time

○ Almost always or always

1. Over the past month, how often did you ingest any **probiotic foods** (such as yogurt, kefir, sauerkraut, kimchi or kombucha)?

○ 1 time or less in the past month

○ 2-3 times in the past month

○ 1 time per week

○ 2 times per week

○ 3-4 times per week

○ 5-6 times per week

○ 1 time per day

○ 2 or more times per day

1. Over the past month, have you taken any **probiotic supplements** (supplementation of healthy bacteria in capsule, powder, or liquid form)?

○ Yes

○ No

1. How would you rate your fiber intake?

○ Very high  
○ Somewhat high  
○ Average  
○ Somewhat low  
○ Very low

# Section B. Anxiety symptoms

Over the past two weeks, how often have you been bothered by the following problems?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all | Several days | Over half the days | Nearly every day |
| 1. Feeling nervous or anxious | ○ | ○ | ○ | ○ |
| 1. Worrying too much about different things | ○ | ○ | ○ | ○ |
| 1. Trouble relaxing | ○ | ○ | ○ | ○ |

Over the past two weeks, please rate the intensity of the following conditions:

1. Problems with Concentration or Attention

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not present | Mild | Moderate | Severe | Very severe |
| ○ | ○ | ○ | ○ | ○ |

1. Trouble functioning at home, work, or socially *due to anxiety* (rate the most troublesome moment).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not present | Mild | Moderate | Severe | Very severe |
| ○ | ○ | ○ | ○ | ○ |

1. Depressed mood (such as loss of interest, lack of pleasure in hobbies)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not present | Mild | Moderate | Severe | Very severe |
| ○ | ○ | ○ | ○ | ○ |

1. Feelings of insomnia

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not present | Mild | Moderate | Severe | Very severe |
| ○ | ○ | ○ | ○ | ○ |

1. Feelings of dry mouth or headaches

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not present | Mild | Moderate | Severe | Very severe |
| ○ | ○ | ○ | ○ | ○ |

1. Feelings of pressure or constriction in the chest

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not present | Mild | Moderate | Severe | Very severe |
| ○ | ○ | ○ | ○ | ○ |

1. Have you experienced any of the following symptoms over the past two weeks? Check all that apply.

Feelings of tension

Concentration difficulties

Blurring of vision

Choking feelings

Unexplained weight loss

Dry mouth

Tendency to sweat

Fidgeting

Tremor of hands

Loss of libido

# Section C. Demographics

1. What was your **age** on your last birthday?  
   years old
2. What **gender** do you identify with?

○ Female

○ Male

○ I identify my gender as: \_\_\_\_\_\_\_\_\_\_\_ (please specify)

Thank you for your participation!