October 2021: One-time Assessment

As a reminder, in an effort to determine the long-term impact of COVID19 on factors related to sleep, mental health, and well-being, we have been releasing occasional one-time assessments and re-initiating the daily surveys from time to time. This has provided us with invaluable information to better understand the long-term effects of the COVID19 pandemic. Presently, we plan for this to be the LAST major assessment period for quite some time.

IF YOU NEED A REMINDER OF YOUR SUBJECT ID - You can enter the email address at which you received this invitation or please email us at cunninaj@bc.edu. Your Subject ID is a 5 digit code composed of letters and/or numbers. It is really important that this is entered correctly so we can match up your current responses with your previous responses.

In this assessment, we will be asking you to report recent changes in sleep behavior and mental health measures. We will also ask you to reflect on your life and experiences since the onset of the COVID19 pandemic, as well as collect more information about your traits and previous experiences that will help us understand different reactions to the pandemic. We estimate this survey to take ~60-75 min, but could take more or less time depending on how much detail you'd like to provide.

In conjunction with this one-time survey, we will be reinitiating the daily surveys from November 1 - November 15, 2021 (EST). All of the assessments are optional and you can opt out of receiving notification or reminders about them at any time by emailing cunninaj@bc.edu.

As compensation, for completion of this survey you will receive one entry into a raffle for one of 125 $20 gift cards (or donations). You will also receive an additional entry for every 3 days of the daily survey you complete. In total you can earn 6 entries into the raffle. The drawing will be scheduled for the end of November.

As always, your health and safety are our number one priority. If diagnosed with COVID-19, we hope and encourage you to seek the treatment and care that you need and recover quickly. Any information that you provide us moving forward will be useful in understanding the effects of COVID-19 and the culture of living though a pandemic, but please do not let keeping up with these surveys interfere with your care in any way.

Thank you!

Subject ID: _____

Click 'Now' _____

Please respond to the following based on your memories and reflections of the early period of the COVID-19 pandemic (March 2020 - May 2020).

When I think about events from March-May 2020, I remember...

...my fears related to the spread of the illness
- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neither disagree nor agree
- ◯ Agree
- ◯ Strongly agree

...the community working together under difficult circumstances
- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neither disagree nor agree
- ◯ Agree
- ◯ Strongly agree

...feeling hope that the efforts will save lives
- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neither disagree nor agree
- ◯ Agree
- ◯ Strongly agree

...the social isolation
- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neither disagree nor agree
- ◯ Agree
- ◯ Strongly agree

...the financial uncertainty
- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neither disagree nor agree
- ◯ Agree
- ◯ Strongly agree

...feeling interconnected with others even while being physically distant
- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neither disagree nor agree
- ◯ Agree
- ◯ Strongly agree

When you reflect back on the earlier phases of the pandemic and the changes it brought to daily life:

	1 = Not at all	2	3	4	5	6	7 = Very much
How nostalgic do you feel?	◯	◯	◯	◯	◯	◯	◯
To what extent do you feel sentimental for that past time?	◯	◯	◯	◯	◯	◯	◯
How much do you feel a wistful affection for that past time?	◯	◯	◯	◯	◯	◯	◯
To what extent do you feel a longing to return to that former time?	◯	◯	◯	◯	◯	◯	◯

When I think back on the events of March-May 2020, part of me longs to return to that time.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neither disagree nor agree
- ◯ Agree
- ◯ Strongly agree

Do you regularly provide unpaid care or assistance (e.g. personal care or support) to any of the following people because of their long-term illness, disability or frailty?

Please indicate all that apply

- ☐ Someone who lives with you
- ☐ Someone who lives elsewhere, and I can access despite current COVID-19 pandemic restrictions
- ☐ Someone who lives elsewhere, and I cannot access due to current COVID-19 pandemic restrictions
- ☐ Someone who is now in a nursing home or hospital, and I can access despite current COVID-19 pandemic restrictions
- ☐ Someone who is now in a nursing home or hospital, and I cannot access due to current COVID-19 pandemic restrictions
- ☐ No, this does not apply

At any point since the start of the COVID-19 pandemic (since January 2020 to present), did you lose access to this person (these people) due to COVID-19 pandemic restrictions?

- ◯ Yes
- ◯ No

Please provide the approximate dates in which your access was revoked due to COVID-19 pandemic restrictions

_____

Moving forward, please read the instructions at the top of each page carefully, as they may be asking you to reflect on different periods of time (e.g. the last month, the last two weeks, etc.)

PSQI: The following questions relate to your usual sleep habits during the PAST MONTH only. Your answers should indicate the most accurate reply for the majority of days and nights in the PAST MONTH.

For questions asking about time, please use military time. For assistance, you may open the attachment or copy and paste this link into a new tab: https://bit.ly/2HG8yuk

During the past month, what time have you usually gone to bed at night?

_____
(Bed time)

During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

_____
(Number of minutes)

During the past month, what time have you usually gotten up in the morning?

_____
(Getting up time)

During the past month, how many hours of ACTUAL SLEEP did you get at night? (This may be different than the number of hours you spent in bed.)

_____
(Hours of sleep per night)

For each of the remaining questions, check the one best response. During the past month, how often have you had trouble sleeping because you . . .

Cannot get to sleep within 30 minutes

◯ Not during the past month
◯ Less than once a week
◯ Once or twice a week
◯ Three or more times a week

Wake up in the middle of the night or early morning

◯ Not during the past month
◯ Less than once a week
◯ Once or twice a week
◯ Three or more times a week

Have to get up to use the bathroom

◯ Not during the past month
◯ Less than once a week
◯ Once or twice a week
◯ Three or more times a week

Cannot breathe comfortably

◯ Not during the past month
◯ Less than once a week
◯ Once or twice a week
◯ Three or more times a week

Cough or snore loudly

◯ Not during the past month
◯ Less than once a week
◯ Once or twice a week
◯ Three or more times a week

Feel too cold

◯ Not during the past month
◯ Less than once a week
◯ Once or twice a week
◯ Three or more times a week

Feel too hot	◯ Not during the past month ◯ Less than once a week ◯ Once or twice a week ◯ Three or more times a week
Had bad dreams	◯ Not during the past month ◯ Less than once a week ◯ Once or twice a week ◯ Three or more times a week
Had pain	◯ Not during the past month ◯ Less than once a week ◯ Once or twice a week ◯ Three or more times a week
Any other reason(s)	◯ Not during the past month ◯ Less than once a week ◯ Once or twice a week ◯ Three or more times a week (If any during past month, please describe below)
If other, please describe:	_____
During the past month, how would you rate your sleep quality overall?	◯ Very good ◯ Fairly good ◯ Fairly bad ◯ Very bad
During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")?	◯ Not during the past month ◯ Less than once a week ◯ Once or twice a week ◯ Three or more times a week
During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?	◯ Not during the past month ◯ Less than once a week ◯ Once or twice a week ◯ Three or more times a week
During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?	◯ No problem at all ◯ Only a very slight problem ◯ Somewhat of a problem ◯ A very big problem

ISI: For each question, please select the option that best describes your answer. Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep	◯	◯	◯	◯	◯
Difficulty staying asleep	◯	◯	◯	◯	◯
Problems waking up too early	◯	◯	◯	◯	◯

How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

◯ Very Satisfied
◯ Satisfied
◯ Moderately Satisfied
◯ Dissatisfied
◯ Very Dissatisfied

How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

◯ Not at all Noticeable
◯ A little
◯ Somewhat
◯ Much
◯ Very Much Noticeable

How WORRIED/DISTRESSED are you about your current sleep problem?

◯ Not at all Worried
◯ A little
◯ Somewhat
◯ Much
◯ Very Much Worried

To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

◯ Not at all Interfering
◯ A little
◯ Somewhat
◯ Much
◯ Very Much Interfering

MCTQ: Now, please estimate an average of your 'normal' sleep behavior over the past 6 weeks.

I have been a shift- or night-worker in the past three months

◯ Yes
◯ No

Normally, I work ____ days per week.

_____
(Enter a number)

Please answer all of the following questions even if you do not work or work 7 days/week. Please continue to enter MILITARY TIME as in the daily surveys. School days can count as workdays.

For assistance, you may open the attachment or copy and paste this link into a new tab: https://bit.ly/2HG8yuk

On WORKDAYS I normally fall asleep at:

_____
(this is NOT when you get into bed, but rather when you fall asleep)

On WORKDAYS I normally wake up at:

_____
(this is NOT when you get out of bed, but rather when you wake up)

On WORK-FREE DAYS when I DO NOT use an alarm clock, I normally fall asleep at:

_____
(this is NOT when you get into bed, but rather when you fall asleep)

On WORK-FREE DAYS when I DO NOT use an alarm clock, I normally wake up at:

_____
(this is NOT when you get out of bed, but rather when you wake up)

PROMIS Fatigue Survey: Please respond to the following based on your personal experience.

In the past 7 days....

How often did you feel tired?	◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always
How often did you experience extreme exhaustion?	◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always
How often did you run out of energy?	◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always
How often did your fatigue limit you at work (including work at home)?	◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always
How often were you too tired to think clearly?	◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always
How often were you too tired to take a bath or shower?	◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always
How often did you have enough energy to exercise strenuously?	◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always

PROMIS Sleep Survey: Please respond to the following based on your personal experience.

In the past 7 days....

My sleep was restless	◯ Not at all ◯ A little bit ◯ Somewhat ◯ Quite a bit ◯ Very much
I was satisfied with my sleep	◯ Not at all ◯ A little bit ◯ Somewhat ◯ Quite a bit ◯ Very much
My sleep was refreshing	◯ Not at all ◯ A little bit ◯ Somewhat ◯ Quite a bit ◯ Very much
I had difficulty falling asleep	◯ Not at all ◯ A little bit ◯ Somewhat ◯ Quite a bit ◯ Very much
I had trouble staying asleep	◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always
I had trouble sleeping	◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always
I got enough sleep	◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always
My sleep quality was	◯ Very poor ◯ Poor ◯ Fair ◯ Good ◯ Very good

I had a hard time getting things done because I was sleepy	◯ Not at all ◯ A little bit ◯ Somewhat ◯ Quite a bit ◯ Very much
I felt alert when I woke up	◯ Not at all ◯ A little bit ◯ Somewhat ◯ Quite a bit ◯ Very much
I felt tired	◯ Not at all ◯ A little bit ◯ Somewhat ◯ Quite a bit ◯ Very much
I had problems during the day because of poor sleep	◯ Not at all ◯ A little bit ◯ Somewhat ◯ Quite a bit ◯ Very much
I had a hard time concentrating because of poor sleep	◯ Not at all ◯ A little bit ◯ Somewhat ◯ Quite a bit ◯ Very much
I felt irritable because of poor sleep	◯ Not at all ◯ A little bit ◯ Somewhat ◯ Quite a bit ◯ Very much
I was sleepy during the daytime	◯ Not at all ◯ A little bit ◯ Somewhat ◯ Quite a bit ◯ Very much
I had trouble staying awake during the day	◯ Not at all ◯ A little bit ◯ Somewhat ◯ Quite a bit ◯ Very much

GAD-7: Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	○	○	○	○
Not being able to stop or control worrying	○	○	○	○
Worrying too much about different things	○	○	○	○
Trouble relaxing	○	○	○	○
Being so restless that it is hard to sit still	○	○	○	○
Becoming easily annoyed or irritable	○	○	○	○
Feeling afraid as if something awful might happen	○	○	○	○

Perceived Stress Scale: The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by selecting the option describing how often you felt or thought a certain way.

	Never	Almost Never	Sometimes	Fairly Often	Very Often
In the last month, how often have you been upset because of something that happened unexpectedly?	○	○	○	○	○
In the last month, how often have you felt that you were unable to control the important things in your life?	○	○	○	○	○
In the last month, how often have you felt nervous and "stressed"?	○	○	○	○	○
In the last month, how often have you felt confident about your ability to handle your personal problems?	○	○	○	○	○
In the last month, how often have you felt that things were going your way?	○	○	○	○	○
In the last month, how often have you found that you could not cope with all the things that you had to do?	○	○	○	○	○
In the last month, how often have you been able to control irritations in your life?	○	○	○	○	○
In the last month, how often have you felt that you were on top of things?	○	○	○	○	○
In the last month, how often have you been angered because of things that were outside of your control?	○	○	○	○	○
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	○	○	○	○	○

LSAS

Read each situation carefully and answer the two following questions about that situation. The first question asks how anxious or fearful you feel in the situation. The second question asks how often you avoid the situation. If you come across a situation that you ordinarily do not experience, imagine "what if you were faced with that situation," and then, rate the degree to which you would fear this hypothetical situation and how often you would tend to avoid it. Please respond to how you would feel about each situation right now, in the moment.

Telephoning in Public

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Participating in small groups

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Eating in public places

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Drinking with others in public places

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Talking to people in authority

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Acting, performing, or giving a talk in front of an audience

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯

	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Going to a party

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯

	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Working while being observed

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯

	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Writing while being observed

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯

	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Calling someone you don't know very well

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯

	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Talking with people you don't know very well

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯

	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Meeting strangers

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯

	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Urinating in a public bathroom

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Entering a room when others are already seated

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Being the center of attention

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Speaking up at a meeting

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Taking a test

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Expressing a disagreement or disapproval to people you don't know very well

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Looking at people you don't know very well in the eyes

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Giving a report to a group

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Trying to pick up someone

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Returning goods to a store

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Giving a party

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Resisting a high pressure salesperson

	None	Mild	Moderate	Severe
Fear	◯	◯	◯	◯
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	◯	◯	◯	◯

Instructions: This is a list of things different people might say about themselves. We are interested in how you would describe yourself. There are no right or wrong answers. So you can describe yourself as honestly as possible, we will keep your responses confidential. We'd like you to take your time and read each statement carefully, selecting the response that best describes you.

	Very False or Often False	Sometimes or Somewhat False	Sometimes or Somewhat True	Very True or Often True
People would describe me as reckless.	○	○	○	○
I feel like I act totally on impulse.	○	○	○	○
Even though I know better, I can't stop making rash decisions.	○	○	○	○
I often feel like nothing I do really matters.	○	○	○	○
Others see me as irresponsible.	○	○	○	○
I'm not good at planning ahead.	○	○	○	○
My thoughts often don't make sense to others.	○	○	○	○
I worry about almost everything.	○	○	○	○
I get emotional easily, often for very little reason.	○	○	○	○
I fear being alone in life more than anything else.	○	○	○	○
I get stuck on one way of doing things, even when it's clear it won't work.	○	○	○	○
I have seen things that weren't really there.	○	○	○	○
I steer clear of romantic relationships.	○	○	○	○
I'm not interested in making friends.	○	○	○	○
I get irritated easily by all sorts of things.	○	○	○	○
I don't like to get too close to people.	○	○	○	○
It's no big deal if I hurt other peoples' feelings.	○	○	○	○
I rarely get enthusiastic about anything.	○	○	○	○
I crave attention.	○	○	○	○

I often have to deal with people who are less important than me.	○	○	○	○
I often have thoughts that make sense to me but that other people say are strange.	○	○	○	○
I use people to get what I want.	○	○	○	○
I often "zone out" and then suddenly come to and realize that a lot of time has passed.	○	○	○	○
Things around me often feel unreal, or more real than usual.	○	○	○	○
It is easy for me to take advantage of others.	○	○	○	○

ISDI

These questions ask about your sleeping habits. Please select "true" if the statement sounds like you and "false" if the statement does not sound like you.

It takes me a long time to fall asleep.	◯ True ◯ False
Most days I feel wide awake.	◯ True ◯ False
I have nightmares frequently.	◯ True ◯ False
I usually wake up feeling refreshed and rested.	◯ True ◯ False
If I wake up during the night, I find it difficult to fall asleep again.	◯ True ◯ False
I rarely take naps.	◯ True ◯ False
My sleep is light.	◯ True ◯ False
I wake up most mornings at roughly the same time.	◯ True ◯ False
I sometimes have a hard time falling asleep due to uncomfortable feelings in my legs.	◯ True ◯ False
Worries don't keep me up at night.	◯ True ◯ False
I move my legs or arms a lot when I sleep.	◯ True ◯ False
I tend to fall asleep quickly.	◯ True ◯ False
I usually feel tired during the day.	◯ True ◯ False
I don't have nightmares.	◯ True ◯ False
I have a hard time waking up during the week.	◯ True ◯ False
I sometimes wake up early and can't get back to sleep.	◯ True ◯ False
I take long naps.	◯ True ◯ False

I am a deep sleeper.	◯ True ◯ False
My bedtime is very irregular.	◯ True ◯ False
I sometimes have cramps or pain in my legs during the night.	◯ True ◯ False
I sometimes lie awake worrying.	◯ True ◯ False
I don't move around much in my sleep.	◯ True ◯ False
I often have trouble falling asleep.	◯ True ◯ False
I get drowsy when I sit still during the day.	◯ True ◯ False
I have recurring bad dreams.	◯ True ◯ False
I usually feel energized after I wake up.	◯ True ◯ False
I wake up frequently during the night.	◯ True ◯ False
I can nap anywhere, in any situation.	◯ True ◯ False
I am easily awakened by noises.	◯ True ◯ False
I go to sleep most evenings at roughly the same time.	◯ True ◯ False
I sometimes have unusual feelings in my legs at night, such as creeping, crawling, tingling, burning, or itching sensations.	◯ True ◯ False
I have trouble sleeping due to nervousness.	◯ True ◯ False
I am told that I kick my legs when I sleep.	◯ True ◯ False
I fall asleep within minutes of going to bed.	◯ True ◯ False
I seem to have less energy than other people I know.	◯ True ◯ False

My dreams often disturb me.	◯ True ◯ False
I feel much worse in the morning than later in the day.	◯ True ◯ False
When I wake up at night, it takes me a long time to get back to sleep.	◯ True ◯ False
I doze off while watching TV during the day.	◯ True ◯ False
I can sleep through loud noises.	◯ True ◯ False
I have trouble getting my sleep into a proper routine.	◯ True ◯ False
I cannot keep my legs still when falling asleep.	◯ True ◯ False
Anxiety sometimes makes it hard for me to fall asleep.	◯ True ◯ False
My legs jerk when I sleep.	◯ True ◯ False
I often lay awake in bed for some time before I finally fall asleep.	◯ True ◯ False
I sometimes don't have enough energy to get things done.	◯ True ◯ False
Nightmares cause me to wake at night.	◯ True ◯ False
I often feel more tired in the morning than when I go to sleep.	◯ True ◯ False
I have trouble staying asleep.	◯ True ◯ False
I sleep a lot during the day.	◯ True ◯ False
People have told me that I can sleep through anything.	◯ True ◯ False
My wake-up time is very irregular.	◯ True ◯ False
I sometimes move my legs around to relieve uncomfortable sensations at night.	◯ True ◯ False

My mind sometimes races when I try to sleep.	◯ True ◯ False
I rarely have trouble falling asleep.	◯ True ◯ False
I frequently have frightening dreams.	◯ True ◯ False
I move around a lot in my sleep.	◯ True ◯ False
I have trouble waking up in the morning.	◯ True ◯ False
I often wake up during the night for no particular reason.	◯ True ◯ False
I doze off when I relax during the day.	◯ True ◯ False
My sleep is easily disturbed.	◯ True ◯ False
I have woken up because of uncomfortable feelings in my legs.	◯ True ◯ False
I sometimes have trouble sleeping because I am thinking about the day's events.	◯ True ◯ False
I am told that I kick or punch in my sleep.	◯ True ◯ False
I find it hard to get my body to relax at bedtime.	◯ True ◯ False
I have a hard time focusing during the day because I am tired.	◯ True ◯ False
I have dreams that are so vivid they influence how I feel the following day.	◯ True ◯ False
I drift off to sleep easily.	◯ True ◯ False
It is difficult for me to pay attention during the day because I am so tired.	◯ True ◯ False
My dreams are often unpleasant.	◯ True ◯ False
I sometimes stay awake thinking about things.	◯ True ◯ False

I usually am still tired when I wake up.	◯ True ◯ False
I sleep very poorly.	◯ True ◯ False
I sometimes try too hard to fall asleep.	◯ True ◯ False
I struggle to remain alert during the day.	◯ True ◯ False
I sometimes have a hard time sleeping due to bad dreams.	◯ True ◯ False
It is very hard for me when I need to get up earlier in the morning.	◯ True ◯ False
I wake up earlier than planned.	◯ True ◯ False
I get sleepy as soon as I'm in bed.	◯ True ◯ False
I have dreams about something bad that happened to me.	◯ True ◯ False
I wake up before I need to.	◯ True ◯ False
Nightmares make it hard for me to fall asleep.	◯ True ◯ False
I have a hard time getting comfortable in bed.	◯ True ◯ False
I often feel sleepy during the day.	◯ True ◯ False
Nightmares cause a physical reaction for me (e.g., sweating, pounding heart, shortness of breath).	◯ True ◯ False
Daytime sleepiness interferes with my activities.	◯ True ◯ False
I sometimes find that I can't move my body when I wake up.	◯ True ◯ False
I experience intense, dreamlike images as I begin to wake up.	◯ True ◯ False
My muscles sometimes feel frozen when I wake up.	◯ True ◯ False

Lying in bed, I sense the presence of someone who isn't actually there.	◯ True ◯ False
When I wake up or fall asleep I am unable to move for a short time.	◯ True ◯ False
I sometimes see or hear things that are not real when falling asleep or waking up.	◯ True ◯ False
I have dream-like images when I awaken in the morning even though I know I am not asleep.	◯ True ◯ False

Demographic Updates

What country have you been in for a majority of the last 3 months?

_____

The following two geographic questions are optional, but information on your location during the pandemic will allow researchers to make a timeline of response measures taken in your area and determine their associations with alterations in your sleep and mood

If US/Canada, what State/Province have you been in for a majority of the last 3 months?

_____

What City have you been in for a majority of the last 3 months?

_____

Do you consider yourself to be at "high-risk" if you contracted COVID19?

◯ Yes
◯ No

Are you a member of any of the following high-risk groups for COVID-19? (Check all that apply)

☐ Healthcare worker
☐ Pre-existing/underlying health condition
☐ Essential worker (e.g. grocery clerk, delivery person)
☐ Smoker/vaper
☐ Taking immunosuppressive medication
☐ Livein a "Hot Zone" (e.g. New York City, Italy)
☐ Other
☐ None of the above

If other, please describe

_____

Do you have a loved one considered to be at "high-risk" if they were to contract COVID19?

◯ Yes
◯ No

Do you live with some one considered to be at "high-risk" if they were to contract COVID19?

◯ Yes
◯ No

Are you a parent?

◯ Yes
◯ No

Did you have children at home with you for a majority of the last 3 months?

◯ Yes
◯ No
(Greater than 50% of the time)

How many children have you had at home with you?

_____
(Number only)

What were the age ranges of the children (Select all that apply):

☐ 0-1 years old
☐ 2-3 years old
☐ 3-5 years old
☐ 6-9 years old
☐ 10-12 years old
☐ 13-15 years old
☐ 15-17 years old
☐ 18+ years old

COVID Impact	
Have you ever received a positive test for COVID19?	◯ Yes ◯ No
Have you ever been diagnosed with COVID19 by a doctor without a formal test?	◯ Yes ◯ No
Do you believe you have ever contracted COVID19 at any point, even without a test or formal diagnosis by a doctor?	◯ Yes ◯ No
How would you rate the severity of the symptoms you experienced/are experiencing?	◯ Mild ◯ Moderate ◯ Severe, but recovered at home ◯ Severe and hospitalized ◯ Hospitalized and needed a ventilator or other lifesaving treatment
Approximate date you contracted COVID19 (Format: Day/Month/Year)	_____
Additional details of COVID19 diagnosis (including additional dates if contracted more than once)	_____
Have you had long-lasting physical impacts due to your COVID19 diagnosis?	◯ Yes ◯ No ((e.g. "COVID long-hauler"))
Has anyone you have lived with contracted COVID19?	◯ Yes ◯ No
Was this confirmed by a test or medical diagnosis?	◯ Yes ◯ No
Has a loved one (family or friend) contracted COVID19?	◯ Yes ◯ No
Was this confirmed by a test or medical diagnosis?	◯ Yes ◯ No
Has a loved one perished due to COVID19?	◯ Yes ◯ No
Has anyone you know personally perished due to COVID19?	◯ Yes ◯ No

It is important to recognize that the devastating impacts of COVID19 have not directly impacted everyone equally, and in fact some people may have experienced some positive outcomes or "silver linings". We will ask some questions about these situations now.

	1 = Completely disagree	2	3	4	5 = Completely agree
Since the start of the pandemic, I have spent more quality time with my immediate family	○	○	○	○	○
Since the start of the pandemic, I have been in more contact with extended family and/or friends	○	○	○	○	○
Since the start of the pandemic, I have had more time for creative pursuits	○	○	○	○	○
Since the start of the pandemic, I have had more time to prioritize sleep	○	○	○	○	○
Since the start of the pandemic, I have benefited financially	○	○	○	○	○
Since the start of the pandemic, I have had more time for my hobbies	○	○	○	○	○
Since the start of the pandemic, I have had more time to exercise/focus on my health	○	○	○	○	○

Please describe other positive impacts of the COVID19 pandemic and the response to it on your life, if any.

_____

	1 = Entirely Negative	2	3	4 = Net Neutral	5	6	7 = Entirely Positive
My experience during the COVID19 pandemic has been...	○	○	○	○	○	○	○

If COVID19 has impacted you directly or indirectly in other ways (both positive and negative) that we have not asked about, please feel free to describe them here.

_____

Vaccination Information	
Have you received any doses of COVID-19 vaccine?	◯ Yes ◯ No
What was the date of your first vaccine dose?	_____ (Format: Month/Day/Year)
Which vaccine did you receive?	_____ (e.g. Pfizer, Moderna, Johnson & Johnson, AstraZeneca)
How many doses of vaccine have you received to date?	◯ 0 ◯ 1 ◯ 2
Did you have any side effects to any doses of vaccination?	◯ No ◯ Yes, mild side effects ◯ Yes, moderate side effects ◯ Yes, severe side effects
Do you plan to receive a COVID-19 vaccination when the opportunity arrives?	◯ Yes ◯ No