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| First session  Instruction. Please circle your answer. | |
| A) |
| 1. How many hours did you sleep last night? |  |
| 1. On a scale of 1 – 5, please rate how well did you sleep last night!   (1: very bad – 5: very good) | 1 2 3 4 5 |
| 1. How many minutes did you need to fall asleep? |  |
| 1. How often did you wake up last night? |  |
| 1. Did you drink coffee today? | YES  NO  If yes, when did you drink your last coffee? |
| 1. Did you take medication in the last 24 hours? | YES  NO  If yes, please provide the name of the medication: |
| 1. Did you consume alcohol in the last 24 hours? | YES  NO  If yes, please indicate how much alcohol did you consume:  little  some  quite a bit  high amount |
| 1. How do you feel yourself at the moment? (1 = very tired - 10 = fully awake) | 1 2 3 4 5  6 7 8 9 10 |
| 1. Do you have headache at the moment? | YES  NO  If yes, how strong is your headache?  (1 = weak - 10 = very strong): |
| 1. Do you have anything else to mention? | YES  NO  If yes, please contact the experimenter. |

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| B) |
| 1. How do you feel yourself at the moment? (1 = very tired - 10 = fully awake) | 1 2 3 4 5  6 7 8 9 10 |
| 1. Did you have headache during the task? | YES  NO  If yes, how strong is your headache?  (1 = weak - 10 = very strong): |
| 1. Do you have anything else to mention? | YES  NO  If yes, please contact the experimenter. |

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| Second session  Instruction. Please circle your answer. | |
| A) |
| 1. How many hours did you sleep last night? |  |
| 1. On a scale of 1 – 5, please rate how well did you sleep last night!   (1: very bad – 5: very good) | 1 2 3 4 5 |
| 1. How many minutes did you need to fall asleep? |  |
| 1. How often did you wake up last night? |  |
| 1. Did you drink coffee today? | YES  NO  If yes, when did you drink your last coffee? |
| 1. Did you take medication in the last 24 hours? | YES  NO  If yes, please provide the name of the medication: |
| 1. Did you consume alcohol in the last 24 hours? | YES  NO  If yes, please indicate how much alcohol did you consume:  little  some  quite a bit  high amount |
| 1. How do you feel yourself at the moment? (1 = very tired - 10 = fully awake) | 1 2 3 4 5  6 7 8 9 10 |
| 1. Do you have headache at the moment? | YES  NO  If yes, how strong is your headache?  (1 = weak - 10 = very strong): |
| 1. What do you think, how will you perform today? | BETTER than yesterday  SAME as yesterday  WORSE than yesterday  What do you think, how strong will this effect be\*?  %  \*( z.B. 10 % better/ worse) |
| 1. Do you have anything else to mention? | YES  NO  If yes, please contact the experimenter. |

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| B) |
| 1. How do you feel yourself at the moment? (1 = very tired - 10 = fully awake) | 1 2 3 4 5  6 7 8 9 10 |
| 1. Did you have headache during the task | YES  NO  If yes, how strong is your headache?  (1 = weak - 10 = very strong): |
| 1. Do you have anything else to mention? | YES  NO  If yes, please contact the experimenter. |
| 1. What do you think, how will you perform today? | BETTER than yesterday  SAME as yesterday  WORSE than yesterday  What do you think, how strong this effect was\*?  %  \*( z.B. 10 % better/ worse) |