




Screening Survey

English    

DEUTSCH / ENGLISH

Welcome!

Thank you for your interest in my study.

Before inviting you to our lab, I would like to **check if you are eligible to participate**: that is what this survey is for. I will ask you **some questions about your health and sleep**.

At the end of the survey, if you are eligible and willing to enrol, you will be asked for information that can identify you (name & email), so we can schedule your first study session. You only decide if you agree to take part in the study or not at that session; consent is not granted just by filling in this survey.

Survey data will be securely stored on the REDCap platform for the duration of the study (Jun - Dec 2023), but you may request the deletion of your data anytime.

Survey completion time: ~ 10 min

What is the study about?

Within my PhD project at TU Munich, I am looking into the **effects of rapidly flickering light on brain activity during sleep**. The goal is to enhance a certain form of brain activity which is impaired in conditions such as Alzheimer's Disease: new research shows that rapidly flickering light can do that. I want to test if applying it during sleep is feasible and effective in young, healthy people. If so, then we can try it on older people at risk for dementia next.

My aim is to help prevent or delay dementia with an intervention that is not invasive, not expensive, and as convenient as possible for patients. *That can only happen with the help of people like you!*

The experiment involves the following sessions:

1. A 1-hour session on a day of your choice, in which you provide your informed consent and the stimulation is applied to you while you are awake.
2. One night at the sleep lab on a weekend, in which only your brain activity is measured, so we can see what your "usual" sleep is like.
3. One more night at the sleep lab (on the following night), in which your brain activity is measured and the light stimulation is activated while you sleep.

On the first session, I am happy to provide more details and answer any questions. Participants are reimbursed for their time with a value of 100 € and are also offered an individualized report of their sleep.

I have read the information above and consider volunteering for this study.

* must provide value



Yes, let's proceed with the questionnaire.

No, I prefer not to take part.

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English   

Exclusion Criteria

You will be asked about some symptoms or disorders you may have experienced. Please answer honestly, so that we can ensure your well-being and safety during the course of this study.

If you are not sure whether something you experienced counts as a symptom or disorder, please choose "maybe" and specify it.

Are you between 18 and 35 years old?

* must provide value

Yes

No

Do you have any difficulty distinguishing between red and green (colour-blindness)?

* must provide value

Yes

No

At any point in your life, have you experienced any of the following:

- Uncontrolled shaking movements of your whole body or parts of it, with full or partial loss of consciousness (*Epilepsy, Seizures*)
- Pulsating headaches possibly accompanied by nausea, sensitivity to light / sound / smell, visual disturbances (*Migraine*)
- Surgery on your brain (e.g., to remove a brain tumor, to perform an implant...)
- Severe concussion
- Stroke
- Other neurological conditions

* must provide value

Yes

Maybe

No

Has any of your first-degree relatives been diagnosed with Epilepsy, or experienced seizures?

* must provide value

Yes

No

(your parents, siblings, or children)

In the past 2 months, have you consumed any of these substances?

- Nicotine
- Cannabis
- Psychopharmacological medication
- Other drugs

* must provide value

Yes

Maybe

No

<p>In the past 6 months, have you experienced any of these sleep disturbances? Or has anyone remarked that you do?</p> <ul style="list-style-type: none">• Regular difficulty falling or staying asleep (<i>Insomnia</i>)• Walking or carrying out complex activities during the night while not fully awake, without remembering them afterward (<i>Sleepwalking</i>)• Involuntary habitual grinding of the teeth during sleep (<i>Bruxism</i>)• Excessive daytime sleepiness with sudden muscle weakness (<i>Narcolepsy</i>)• Unpleasant "creeping" sensation and pain in the lower legs that can be relieved by movement of the legs, such as walking or kicking (<i>Restless Legs Syndrome</i>)• Periodically interrupted breathing during sleep that causes gasping or "snorting" noises, more than just snoring (<i>Sleep Apnoea</i>) <p>* must provide value</p>	<div>Yes</div> <div>Maybe</div> <div>No</div>
<p><u>In the past 6 months</u>, have you experienced any of these psychiatric symptoms?</p> <ul style="list-style-type: none">• Depressed mood• Extreme mood swings• Excessive fears or worries• Substance abuse• Hallucinations or paranoia• Suicidal thoughts• Other mental issues <p>* must provide value</p>	<div>Yes</div> <div>Maybe</div> <div>No</div>
<p><u>In the past month</u>, I have been a shift- or night-worker:</p> <p>* must provide value</p>	<div>Yes</div> <div>No</div>
<p><u>In the past month</u>, I have travelled across two or more time zones:</p> <p>* must provide value</p>	<div>Yes</div> <div>No</div>
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