Participant Information Survey

1. Name (First/Last): _____

2. Do you have a current, medical diagnosis of any neurological, psychiatry, or psychological conditions (circle one)?

YES NO

3. Do you have a current diagnosis for a sleep disorder and/or are you taking any prescription medication that could affect sleep (circle one)?

YES NO

IMPORTANT: If you answered Yes to either Question 2 or 3, please do not continue with this questionnaire and talk to the investigator.

4. Age (years): _____

5. Gender (circle one): Male Female Other

6. Handedness (circle): Right Left Both

7. Employment Status: _____

8. Please check if you engage in either of the following activities (at least 3 times per week on average for the last 3 months)

Napping _____ If yes, what time do you typically nap? _____

Meditation _____ If yes, describe your technique: _____

How long have you been practicing? _____

9. At what time do you typically go to sleep? _____

At what time do you typically get up? _____

10. How would you characterize your typical sleep quality (circle one)?

A. I have no trouble sleeping and usually feel that I get enough sleep and am well-rested
B. I generally sleep well, but occasionally suffer from lack of enough sleep

C. My sleep is quite mixed; at times I sleep well, but at other times, I suffer from sleep loss and tiredness

D. I am a poor sleeper and it is rare for me to get enough sleep and feel well-rested

E. I suffer from chronic sleep loss and feel that my daytime functioning is impaired due to the poor quality of my sleep

Participant Code (condition + subject number): _____
C = control (movie); N = nap; M = meditate