Experienced Sleep Quality Questionnaire

Participant Name: _____

Trial #: ___

What is your age? _____

What gender do you identify as? _____

Do you have any pre-existing sleep disorders? Y / N

Do you currently have any health conditions that may affect the quality of your sleep? Y / N

How was your experienced quality of your sleep last night, on a scale from 1=worst to 10=best?

1 2 3 4 5 6 7 8 9 10

How many times do you think you woke up after falling asleep last night?

_____

How long (in hours or minutes) do you think it took for you to fall asleep?

_____

How long (in hours or minutes) do you think you slept last night?

_____

Reminder: You can opt-out of this questionnaire at any time, and if you choose to do so, your data and personal information will not be used in this project and will be immediately deleted.