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.