



Boston College daily sleep and well-being survey data during early phase of the COVID-19 pandemic

Citation

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October 2021: One-time Assessment

As a reminder, in an effort to determine the long-term impact of COVID19 on factors related to sleep, mental health, and well-being, we have been releasing occasional one-time assessments and re-initiating the daily surveys from time to time. This has provided us with invaluable information to better understand the long-term effects of the COVID19 pandemic. Presently, we plan for this to be the LAST major assessment period for quite some time.

IF YOU NEED A REMINDER OF YOUR SUBJECT ID - You can enter the email address at which you received this invitation or please email us at cunninaj@bc.edu. Your Subject ID is a 5 digit code composed of letters and/or numbers. It is really important that this is entered correctly so we can match up your current responses with your previous responses.

In this assessment, we will be asking you to report recent changes in sleep behavior and mental health measures. We will also ask you to reflect on your life and experiences since the onset of the COVID19 pandemic, as well as collect more information about your traits and previous experiences that will help us understand different reactions to the pandemic. We estimate this survey to take ~60-75 min, but could take more or less time depending on how much detail you'd like to provide.

In conjunction with this one-time survey, we will be reinitiating the daily surveys from November 1 - November 15, 2021 (EST). All of the assessments are optional and you can opt out of receiving notification or reminders about them at any time by emailing cunninaj@bc.edu.

As compensation, for completion of this survey you will receive one entry into a raffle for one of 125 \$20 gift cards (or donations). You will also receive an additional entry for every 3 days of the daily survey you complete. In total you can earn 6 entries into the raffle. The drawing will be scheduled for the end of November.

As always, your health and safety are our number one priority. If diagnosed with COVID-19, we hope and encourage you to seek the treatment and care that you need and recover quickly. Any information that you provide us moving forward will be useful in understanding the effects of COVID-19 and the culture of living through a pandemic, but please do not let keeping up with these surveys interfere with your care in any way.

Thank you!

Subject ID:

Click 'Now'

Please respond to the following based on your memories and reflections of the early period of the COVID-19 pandemic (March 2020 - May 2020).

When I think about events from March-May 2020, I remember...

...my fears related to the spread of the illness

- Strongly Disagree
 Disagree
 Neither disagree nor agree
 Agree
 Strongly agree

...the community working together under difficult circumstances

- Strongly Disagree
 Disagree
 Neither disagree nor agree
 Agree
 Strongly agree

...feeling hope that the efforts will save lives

- Strongly Disagree
 Disagree
 Neither disagree nor agree
 Agree
 Strongly agree

...the social isolation

- Strongly Disagree
 Disagree
 Neither disagree nor agree
 Agree
 Strongly agree

...the financial uncertainty

- Strongly Disagree
 Disagree
 Neither disagree nor agree
 Agree
 Strongly agree

...feeling interconnected with others even while being physically distant

- Strongly Disagree
 Disagree
 Neither disagree nor agree
 Agree
 Strongly agree

When you reflect back on the earlier phases of the pandemic and the changes it brought to daily life:

	1 = Not at all	2	3	4	5	6	7 = Very much
How nostalgic do you feel?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
To what extent do you feel sentimental for that past time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How much do you feel a wistful affection for that past time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
To what extent do you feel a longing to return to that former time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When I think back on the events of March-May 2020,
part of me longs to return to that time.

- Strongly Disagree
- Disagree
- Neither disagree nor agree
- Agree
- Strongly agree

Do you regularly provide unpaid care or assistance (e.g. personal care or support) to any of the following people because of their long-term illness, disability or frailty?

Please indicate all that apply

- Someone who lives with you
- Someone who lives elsewhere, and I can access despite current COVID-19 pandemic restrictions
- Someone who lives elsewhere, and I cannot access due to current COVID-19 pandemic restrictions
- Someone who is now in a nursing home or hospital, and I can access despite current COVID-19 pandemic restrictions
- Someone who is now in a nursing home or hospital, and I cannot access due to current COVID-19 pandemic restrictions
- No, this does not apply

At any point since the start of the COVID-19 pandemic (since January 2020 to present), did you lose access to this person (these people) due to COVID-19 pandemic restrictions?

- Yes
- No

Please provide the approximate dates in which your access was revoked due to COVID-19 pandemic restrictions

Moving forward, please read the instructions at the top of each page carefully, as they may be asking you to reflect on different periods of time (e.g. the last month, the last two weeks, etc.)

PSQI: The following questions relate to your usual sleep habits during the PAST MONTH only. Your answers should indicate the most accurate reply for the majority of days and nights in the PAST MONTH.

For questions asking about time, please use military time. For assistance, you may open the attachment or copy and paste this link into a new tab: <https://bit.ly/2HG8yuk>

During the past month, what time have you usually gone to bed at night?

_____ (Bed time)

During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

_____ (Number of minutes)

During the past month, what time have you usually gotten up in the morning?

_____ (Getting up time)

During the past month, how many hours of ACTUAL SLEEP did you get at night? (This may be different than the number of hours you spent in bed.)

_____ (Hours of sleep per night)

For each of the remaining questions, check the one best response. During the past month, how often have you had trouble sleeping because you . . .

Cannot get to sleep within 30 minutes

- Not during the past month
 Less than once a week
 Once or twice a week
 Three or more times a week

Wake up in the middle of the night or early morning

- Not during the past month
 Less than once a week
 Once or twice a week
 Three or more times a week

Have to get up to use the bathroom

- Not during the past month
 Less than once a week
 Once or twice a week
 Three or more times a week

Cannot breathe comfortably

- Not during the past month
 Less than once a week
 Once or twice a week
 Three or more times a week

Cough or snore loudly

- Not during the past month
 Less than once a week
 Once or twice a week
 Three or more times a week

Feel too cold

- Not during the past month
 Less than once a week
 Once or twice a week
 Three or more times a week

Feel too hot

- Not during the past month
 Less than once a week
 Once or twice a week
 Three or more times a week

Had bad dreams

- Not during the past month
 Less than once a week
 Once or twice a week
 Three or more times a week

Had pain

- Not during the past month
 Less than once a week
 Once or twice a week
 Three or more times a week

Any other reason(s)

- Not during the past month
 Less than once a week
 Once or twice a week
 Three or more times a week
(If any during past month, please describe below)

If other, please describe:

During the past month, how would you rate your sleep quality overall?

- Very good
 Fairly good
 Fairly bad
 Very bad

During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")?

- Not during the past month
 Less than once a week
 Once or twice a week
 Three or more times a week

During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

- Not during the past month
 Less than once a week
 Once or twice a week
 Three or more times a week

During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

- No problem at all
 Only a very slight problem
 Somewhat of a problem
 A very big problem

ISI: For each question, please select the option that best describes your answer. Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problems waking up too early	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

- Very Satisfied
 Satisfied
 Moderately Satisfied
 Dissatisfied
 Very Dissatisfied

How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

- Not at all Noticeable
 A little
 Somewhat
 Much
 Very Much Noticeable

How WORRIED/DISTRESSED are you about your current sleep problem?

- Not at all Worried
 A little
 Somewhat
 Much
 Very Much Worried

To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

- Not at all Interfering
 A little
 Somewhat
 Much
 Very Much Interfering

MCTQ: Now, please estimate an average of your 'normal' sleep behavior over the past 6 weeks.

I have been a shift- or night-worker in the past three months

Yes
 No

Normally, I work ___ days per week.

(Enter a number)

Please answer all of the following questions even if you do not work or work 7 days/week. Please continue to enter MILITARY TIME as in the daily surveys. School days can count as workdays.

For assistance, you may open the attachment or copy and paste this link into a new tab: <https://bit.ly/2HG8yuk>

On WORKDAYS I normally fall asleep at:

(this is NOT when you get into bed, but rather when you fall asleep)

On WORKDAYS I normally wake up at:

(this is NOT when you get out of bed, but rather when you wake up)

On WORK-FREE DAYS when I DO NOT use an alarm clock, I normally fall asleep at:

(this is NOT when you get into bed, but rather when you fall asleep)

On WORK-FREE DAYS when I DO NOT use an alarm clock, I normally wake up at:

(this is NOT when you get out of bed, but rather when you wake up)

PROMIS Fatigue Survey: Please respond to the following based on your personal experience.**In the past 7 days....**

How often did you feel tired?

- Never
- Rarely
- Sometimes
- Often
- Always

How often did you experience extreme exhaustion?

- Never
- Rarely
- Sometimes
- Often
- Always

How often did you run out of energy?

- Never
- Rarely
- Sometimes
- Often
- Always

How often did your fatigue limit you at work
(including work at home)?

- Never
- Rarely
- Sometimes
- Often
- Always

How often were you too tired to think clearly?

- Never
- Rarely
- Sometimes
- Often
- Always

How often were you too tired to take a bath or shower?

- Never
- Rarely
- Sometimes
- Often
- Always

How often did you have enough energy to exercise
strenuously?

- Never
- Rarely
- Sometimes
- Often
- Always

PROMIS Sleep Survey: Please respond to the following based on your personal experience.**In the past 7 days....**

My sleep was restless

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

I was satisfied with my sleep

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

My sleep was refreshing

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

I had difficulty falling asleep

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

I had trouble staying asleep

- Never
- Rarely
- Sometimes
- Often
- Always

I had trouble sleeping

- Never
- Rarely
- Sometimes
- Often
- Always

I got enough sleep

- Never
- Rarely
- Sometimes
- Often
- Always

My sleep quality was

- Very poor
- Poor
- Fair
- Good
- Very good

I had a hard time getting things done because I was sleepy

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

I felt alert when I woke up

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

I felt tired

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

I had problems during the day because of poor sleep

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

I had a hard time concentrating because of poor sleep

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

I felt irritable because of poor sleep

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

I was sleepy during the daytime

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

I had trouble staying awake during the day

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

GAD-7: Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worrying too much about different things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble relaxing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being so restless that it is hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling afraid as if something awful might happen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Perceived Stress Scale: The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by selecting the option describing how often you felt or thought a certain way.

	Never	Almost Never	Sometimes	Fairly Often	Very Often
In the last month, how often have you been upset because of something that happened unexpectedly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In the last month, how often have you felt that you were unable to control the important things in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In the last month, how often have you felt nervous and "stressed"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In the last month, how often have you felt confident about your ability to handle your personal problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In the last month, how often have you felt that things were going your way?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In the last month, how often have you found that you could not cope with all the things that you had to do?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In the last month, how often have you been able to control irritations in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In the last month, how often have you felt that you were on top of things?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In the last month, how often have you been angered because of things that were outside of your control?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

LSAS

Read each situation carefully and answer the two following questions about that situation. The first question asks how anxious or fearful you feel in the situation. The second question asks how often you avoid the situation. If you come across a situation that you ordinarily do not experience, imagine "what if you were faced with that situation," and then, rate the degree to which you would fear this hypothetical situation and how often you would tend to avoid it. Please respond to how you would feel about each situation right now, in the moment.

Telephoning in Public

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Participating in small groups

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Eating in public places

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Drinking with others in public places

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Talking to people in authority

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Acting, performing, or giving a talk in front of an audience

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Going to a party				
	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Working while being observed				
	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Writing while being observed				
	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Calling someone you don't know very well				
	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Talking with people you don't know very well				
	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meeting strangers				
	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Urinating in a public bathroom				

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Entering a room when others are already seated

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Being the center of attention

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Speaking up at a meeting

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Taking a test

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Expressing a disagreement or disapproval to people you don't know very well

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Looking at people you don't know very well in the eyes

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Giving a report to a group

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Trying to pick up someone

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Returning goods to a store

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Giving a party

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Resisting a high pressure salesperson

	None	Mild	Moderate	Severe
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never (0%)	Occasionally (1-33%)	Often (34-66%)	Usually (67-100%)
Avoidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Instructions: This is a list of things different people might say about themselves. We are interested in how you would describe yourself. There are no right or wrong answers. So you can describe yourself as honestly as possible, we will keep your responses confidential. We'd like you to take your time and read each statement carefully, selecting the response that best describes you.

	Very False or Often False	Sometimes or Somewhat False	Sometimes or Somewhat True	Very True or Often True
People would describe me as reckless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel like I act totally on impulse.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Even though I know better, I can't stop making rash decisions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I often feel like nothing I do really matters.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Others see me as irresponsible.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I'm not good at planning ahead.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My thoughts often don't make sense to others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I worry about almost everything.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I get emotional easily, often for very little reason.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I fear being alone in life more than anything else.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I get stuck on one way of doing things, even when it's clear it won't work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have seen things that weren't really there.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I steer clear of romantic relationships.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I'm not interested in making friends.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I get irritated easily by all sorts of things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I don't like to get too close to people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It's no big deal if I hurt other peoples' feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I rarely get enthusiastic about anything.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I crave attention.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I often have to deal with people who are less important than me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I often have thoughts that make sense to me but that other people say are strange.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I use people to get what I want.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I often "zone out" and then suddenly come to and realize that a lot of time has passed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Things around me often feel unreal, or more real than usual.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is easy for me to take advantage of others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ISDI

These questions ask about your sleeping habits. Please select "true" if the statement sounds like you and "false" if the statement does not sound like you.

It takes me a long time to fall asleep. True
 False

Most days I feel wide awake. True
 False

I have nightmares frequently. True
 False

I usually wake up feeling refreshed and rested. True
 False

If I wake up during the night, I find it difficult to fall asleep again. True
 False

I rarely take naps. True
 False

My sleep is light. True
 False

I wake up most mornings at roughly the same time. True
 False

I sometimes have a hard time falling asleep due to uncomfortable feelings in my legs. True
 False

Worries don't keep me up at night. True
 False

I move my legs or arms a lot when I sleep. True
 False

I tend to fall asleep quickly. True
 False

I usually feel tired during the day. True
 False

I don't have nightmares. True
 False

I have a hard time waking up during the week. True
 False

I sometimes wake up early and can't get back to sleep. True
 False

I take long naps. True
 False

-
- I am a deep sleeper. True
 False
-
- My bedtime is very irregular. True
 False
-
- I sometimes have cramps or pain in my legs during the night. True
 False
-
- I sometimes lie awake worrying. True
 False
-
- I don't move around much in my sleep. True
 False
-
- I often have trouble falling asleep. True
 False
-
- I get drowsy when I sit still during the day. True
 False
-
- I have recurring bad dreams. True
 False
-
- I usually feel energized after I wake up. True
 False
-
- I wake up frequently during the night. True
 False
-
- I can nap anywhere, in any situation. True
 False
-
- I am easily awakened by noises. True
 False
-
- I go to sleep most evenings at roughly the same time. True
 False
-
- I sometimes have unusual feelings in my legs at night, such as creeping, crawling, tingling, burning, or itching sensations. True
 False
-
- I have trouble sleeping due to nervousness. True
 False
-
- I am told that I kick my legs when I sleep. True
 False
-
- I fall asleep within minutes of going to bed. True
 False
-
- I seem to have less energy than other people I know. True
 False

-
- My dreams often disturb me. True
 False
-
- I feel much worse in the morning than later in the day. True
 False
-
- When I wake up at night, it takes me a long time to get back to sleep. True
 False
-
- I doze off while watching TV during the day. True
 False
-
- I can sleep through loud noises. True
 False
-
- I have trouble getting my sleep into a proper routine. True
 False
-
- I cannot keep my legs still when falling asleep. True
 False
-
- Anxiety sometimes makes it hard for me to fall asleep. True
 False
-
- My legs jerk when I sleep. True
 False
-
- I often lay awake in bed for some time before I finally fall asleep. True
 False
-
- I sometimes don't have enough energy to get things done. True
 False
-
- Nightmares cause me to wake at night. True
 False
-
- I often feel more tired in the morning than when I go to sleep. True
 False
-
- I have trouble staying asleep. True
 False
-
- I sleep a lot during the day. True
 False
-
- People have told me that I can sleep through anything. True
 False
-
- My wake-up time is very irregular. True
 False
-
- I sometimes move my legs around to relieve uncomfortable sensations at night. True
 False

-
- My mind sometimes races when I try to sleep. True
 False
-
- I rarely have trouble falling asleep. True
 False
-
- I frequently have frightening dreams. True
 False
-
- I move around a lot in my sleep. True
 False
-
- I have trouble waking up in the morning. True
 False
-
- I often wake up during the night for no particular reason. True
 False
-
- I doze off when I relax during the day. True
 False
-
- My sleep is easily disturbed. True
 False
-
- I have woken up because of uncomfortable feelings in my legs. True
 False
-
- I sometimes have trouble sleeping because I am thinking about the day's events. True
 False
-
- I am told that I kick or punch in my sleep. True
 False
-
- I find it hard to get my body to relax at bedtime. True
 False
-
- I have a hard time focusing during the day because I am tired. True
 False
-
- I have dreams that are so vivid they influence how I feel the following day. True
 False
-
- I drift off to sleep easily. True
 False
-
- It is difficult for me to pay attention during the day because I am so tired. True
 False
-
- My dreams are often unpleasant. True
 False
-
- I sometimes stay awake thinking about things. True
 False

I usually am still tired when I wake up.

- True
 False

I sleep very poorly.

- True
 False

I sometimes try too hard to fall asleep.

- True
 False

I struggle to remain alert during the day.

- True
 False

I sometimes have a hard time sleeping due to bad dreams.

- True
 False

It is very hard for me when I need to get up earlier in the morning.

- True
 False

I wake up earlier than planned.

- True
 False

I get sleepy as soon as I'm in bed.

- True
 False

I have dreams about something bad that happened to me.

- True
 False

I wake up before I need to.

- True
 False

Nightmares make it hard for me to fall asleep.

- True
 False

I have a hard time getting comfortable in bed.

- True
 False

I often feel sleepy during the day.

- True
 False

Nightmares cause a physical reaction for me (e.g., sweating, pounding heart, shortness of breath).

- True
 False

Daytime sleepiness interferes with my activities.

- True
 False

I sometimes find that I can't move my body when I wake up.

- True
 False

I experience intense, dreamlike images as I begin to wake up.

- True
 False

My muscles sometimes feel frozen when I wake up.

- True
 False

Lying in bed, I sense the presence of someone who isn't actually there.

- True
 False

When I wake up or fall asleep I am unable to move for a short time.

- True
 False

I sometimes see or hear things that are not real when falling asleep or waking up.

- True
 False

I have dream-like images when I awaken in the morning even though I know I am not asleep.

- True
 False

Demographic Updates

What country have you been in for a majority of the last 3 months?

The following two geographic questions are optional, but information on your location during the pandemic will allow researchers to make a timeline of response measures taken in your area and determine their associations with alterations in your sleep and mood

If US/Canada, what State/Province have you been in for a majority of the last 3 months?

What City have you been in for a majority of the last 3 months?

Do you consider yourself to be at "high-risk" if you contracted COVID19?

- Yes
 No

Are you a member of any of the following high-risk groups for COVID-19? (Check all that apply)

- Healthcare worker
 Pre-existing/underlying health condition
 Essential worker (e.g. grocery clerk, delivery person)
 Smoker/vaper
 Taking immunosuppressive medication
 Live in a "Hot Zone" (e.g. New York City, Italy)
 Other
 None of the above

If other, please describe

Do you have a loved one considered to be at "high-risk" if they were to contract COVID19?

- Yes
 No

Do you live with some one considered to be at "high-risk" if they were to contract COVID19?

- Yes
 No

Are you a parent?

- Yes
 No

Did you have children at home with you for a majority of the last 3 months?

- Yes
 No
(Greater than 50% of the time)

How many children have you had at home with you?

_____ (Number only)

What were the age ranges of the children (Select all that apply):

- 0-1 years old
 2-3 years old
 3-5 years old
 6-9 years old
 10-12 years old
 13-15 years old
 15-17 years old
 18+ years old

COVID Impact

Have you ever received a positive test for COVID19? Yes
 No

Have you ever been diagnosed with COVID19 by a doctor without a formal test? Yes
 No

Do you believe you have ever contracted COVID19 at any point, even without a test or formal diagnosis by a doctor? Yes
 No

How would you rate the severity of the symptoms you experienced/are experiencing? Mild
 Moderate
 Severe, but recovered at home
 Severe and hospitalized
 Hospitalized and needed a ventilator or other lifesaving treatment

Approximate date you contracted COVID19

(Format: Day/Month/Year)

Additional details of COVID19 diagnosis (including additional dates if contracted more than once)

Have you had long-lasting physical impacts due to your COVID19 diagnosis? Yes
 No
(e.g. "COVID long-hauler")

Has anyone you have lived with contracted COVID19? Yes
 No

Was this confirmed by a test or medical diagnosis? Yes
 No

Has a loved one (family or friend) contracted COVID19? Yes
 No

Was this confirmed by a test or medical diagnosis? Yes
 No

Has a loved one perished due to COVID19? Yes
 No

Has anyone you know personally perished due to COVID19? Yes
 No

It is important to recognize that the devastating impacts of COVID19 have not directly impacted everyone equally, and in fact some people may have experienced some positive outcomes or "silver linings". We will ask some questions about these situations now.

	1 = Completely disagree	2	3	4	5 = Completely agree
Since the start of the pandemic, I have spent more quality time with my immediate family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Since the start of the pandemic, I have been in more contact with extended family and/or friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Since the start of the pandemic, I have had more time for creative pursuits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Since the start of the pandemic, I have had more time to prioritize sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Since the start of the pandemic, I have benefited financially	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Since the start of the pandemic, I have had more time for my hobbies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Since the start of the pandemic, I have had more time to exercise/focus on my health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please describe other positive impacts of the COVID19 pandemic and the response to it on your life, if any.

	1 = Entirely Negative	2	3	4 = Net Neutral	5	6	7 = Entirely Positive
My experience during the COVID19 pandemic has been...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If COVID19 has impacted you directly or indirectly in other ways (both positive and negative) that we have not asked about, please feel free to describe them here.

Vaccination Information

Have you received any doses of COVID-19 vaccine? Yes
 No

What was the date of your first vaccine dose?

(Format: Month/Day/Year)

Which vaccine did you receive?

(e.g. Pfizer, Moderna, Johnson & Johnson, AstraZeneca)

How many doses of vaccine have you received to date? 0
 1
 2

Did you have any side effects to any doses of vaccination? No
 Yes, mild side effects
 Yes, moderate side effects
 Yes, severe side effects

Do you plan to receive a COVID-19 vaccination when the opportunity arrives? Yes
 No