



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

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FINAL COVID19 Daily Survey

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 today 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. Feel free to only respond if you are feeling up to it today.

If you are feeling up to it today, please take a few minutes to fill out this form at your earliest possible convenience, while the information is still fresh in your memory.

As a reminder, we have included some additional questions to this final daily survey to collect information on just a few more things before we wrap up. These questions will appear at the end of the typical Full Version of the survey.

Subject ID

(Provided to you in initial email with link to demographic survey)

Today's Date (Click 'Now')

Last Night's Sleep

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>

What time did you get into bed last night?

What time did you try to fall asleep last night?

How long did it take you to fall asleep last night (in minutes)?

Approximately how many times did you wake up during the night last night?

- 0
 1
 2
 3
 4
 5 or more times

In total, how long were you up during the night due to these awakenings (in minutes)?

What time did you wake up this morning?

What time did you get out of bed this morning?

How easy was it to fall asleep last night?

- It was easy
 It took some time
 It was difficult

Did you dream last night?

- Yes
 No
 I don't recall

Please describe in as much detail as you'd like the content of your dreams last night.

Did you take a nap yesterday?

- Yes
 No

How many minutes was your nap yesterday?

Were the values reported here influenced/assisted by a sleep tracker of any kind (e.g. Fitbit, Apple Watch, etc)?

- Yes
 No

Feel free to include any other relevant information about your sleep here, including any disturbances that contributed to you waking up during the night.

Yesterday's Activity

Do you have a step counter?

- Yes
 No

If yes, please record the number of steps you took yesterday.

Did you leave your house yesterday?

- Yes
 No

What places did you visit outside of your home yesterday?

Outside of the people that you live with, approximately how many people did you come into face-to-face contact with yesterday?

(Within "social distance" of 6ft or 2 meters)

Did you do anything to socialize virtually or via phone with family or friends?

- Yes
 No

How much time did you spend socializing virtually or via phone (in minutes)?

Did you exercise for 20 minutes or more yesterday?

- No
 Yes, in the morning
 Yes, in the afternoon
 Yes, in the evening

How many alcoholic beverages did you consume yesterday?

Coronavirus Status

Are you in quarantine? Yes
 No

How many days have you been in quarantine?

Are you experiencing a fever? Yes
 No

How severe has your fever been over the last 24 hours?

	Mild				Moderate				Severe
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What was your last recorded temperature?

Temperature Units Celsius
 Fahrenheit

Are you experiencing any respiratory symptoms? Yes
 No
(e.g. coughing, difficulty breathing)

If yes, please describe

How severe have your respiratory symptoms been over the last 24 hours?

	Mild				Moderate				Severe
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you been tested for COVID-19 (i.e. coronavirus)? Yes
 No

Have you been diagnosed with COVID-19 (i.e. coronavirus)? Yes
 No

As a reminder, for confidentiality purposes we are not tracking your responses in real time, nor are we using your responses to generate any diagnoses. If experiencing any symptoms, please be sure to follow guidelines of medical professionals and seek appropriate treatment as needed.

CURRENT FEELINGS AND MOOD

For each of the following personal attributes, indicate which description best describes how you currently feel, right now in the moment.

	Very slightly/not at all	A little	Moderately	Quite a bit	Extremely
Interested	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Distressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excited	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Upset	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strong	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Guilty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Scared	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hostile	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enthusiastic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Proud	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alert	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ashamed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inspired	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nervous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Determined	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Attentive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jittery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Active	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Afraid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Happy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Angry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Completely isolated				Not isolated at all/ Socially fulfilled
How socially isolated do you feel?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Completely consumed with worry				Not worried at all
How worried are you about your own health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How worried are you about the health of your family and friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How worried are you about the health of those in your community?

How worried are you about COVID-19 as it is related to a national/global public health crisis?

How worried are you about your own finances or the impact of COVID-19 on national/global markets?

Completely
consumed
by stress

Not
stressed at
all

How stressed do you currently feel overall?

In the last several days, how often have you been bothered by any of the following problems?

	Not at all	Some of the time	More than half the time	Almost all of the time
Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble falling asleep, staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling bad about yourself- or that you are a failure or that you have let yourself or your family down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble concentrating on things, such as reading the news or watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Moving or speaking so slowly that other people could have noticed? - or the opposite problem - being so fidgety or restless that you have been moving around a lot more than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Estimations

Instructions: In this section, we would like to collect some information regarding your ability to estimate certain statistics you may have heard about previously. Please do not look up any supporting information to respond to these questions. It is totally fine to completely guess if you are unsure.

Have you been residing in the US for a majority of the last year? Yes No

Approximately how many individuals on average are diagnosed with breast cancer in the US annually? _____

Approximately how many people voted in the 2020 US election? _____

Approximately how many total COVID-19 cases were confirmed in the US by the end of October 2021? _____

Approximately how many total COVID-19 cases were confirmed in your STATE by the end of October 2021? _____

State: _____
(This should be the state that you estimated for in the previous question)

Approximately how many individuals on average are diagnosed with breast cancer in your country annually? _____

Approximately how many total COVID-19 cases were confirmed in your country by the end of October 2021? _____

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

1 = Entirely Negative 2 3 4 = Net Neutral 5 6 7 = Entirely Positive

My experience during the
COVID19 pandemic has been...

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
 3

Did you have any side effects to any doses of your original vaccination (not including any booster shots)? No
 Yes, mild side effects
 Yes, moderate side effects
 Yes, severe side effects

Have you received a booster dose of the COVID-19 vaccination? Yes
 No

What was the date of your booster dose?

(Format: Month/Day/Year)

Which vaccine did you receive for your booster?

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

Did you have any side effects to your booster dose of the COVID-19 vaccination? No
 Yes, mild side effects
 Yes, moderate side effects
 Yes, severe side effects

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

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

Final Question

OPTIONAL: This is the FINAL planned assessment question for the study! Please let us know anything else you feel like sharing. Responses can include additional details regarding your experiences during COVID-19 or with your experience as being a participant in this study.
