

## 1. What colour are your eyes?

Please tick one box

Amber  Green  Blue

Hazel  Brown  Red

Grey  Don't Know

## 2. Would you say your health during the COVID-19 pandemic was...

Please tick one box

Excellent  Very Good  Good  Fair  Poor

## 3. What about your emotional or mental health during the COVID-19 pandemic? Was it...

Please tick one box

Excellent  Very Good  Good  Fair  Poor

## 4. Overall, how satisfied are you with your life nowadays?

Please circle one number

1 = not at all satisfied 10 = completely satisfied 1 2 3 4 5 6 7 8 9 10 N/A

**5. The next questions are about how you felt about different aspects of your life during the COVID-19 pandemic. For each one, please say how often you felt that way.**

Please tick one box per line	Often	Some of the time	Hardly ever or never
How often do you feel you lack companionship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel left out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel isolated from others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel in tune with the people around you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel lonely?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**6. For each item in the list below, please indicate how often you have felt or behaved this way during the last 7 days?**

Please tick one box per line	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	All of the time (5-7 days)
I felt depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt that everything I did was an effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My sleep was restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I was happy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I enjoyed life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I could not get "going"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**9. The next four questions are also about how you have felt during the COVID-19 pandemic.**

Please tick one box per line	Hardly ever	Almost never	Sometimes	Fairly often	Very often
How often have you felt that you were unable to control the important things in your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often have you felt confident about your ability to handle your personal problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often have you felt that things were going your way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often have you felt difficulties were piling up so high that you could not overcome them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**10. For each item in the list below, please indicate how often you have felt or behaved this way during the last 7 days?**

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

**11. Approximately how many hours do you sleep on a week night?**

Hours \_\_\_\_\_

Please tick one box per line	Rarely / never	Sometimes	Most of the time
11.1 How often do you have trouble falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.2 How often do you have trouble with waking up too early and not being able to fall asleep again?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**12. Since the COVID-19 pandemic, has the quality of any of your relationships with people outside your household changed?**

Please tick one box per line	Better	Worse	About the same	Not relevant
Your children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your grandchildren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your neighbours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>