January 28, 2019

UNIVERSITY OF SASKATCHEWAN

First Nations Sleep Health Project - Adult Survey

Beardy's and Okemasis Cree Nation
Montreal Lake Cree Nation

TANSI: Thank you for filling out this questionnaire.

I am _____ and I am a member of the research team. Thank you for your participation. Your support is very important to the success of this project.

It will take you about 30 minutes to answer. Any information you provide to us will be kept completely private. Your name will not be used. Instead we will give you a study number so that the information you give us cannot be connected to your name. All the results from the study will be given as group statistics so no single person or house can be known.

Please try to answer all of the questions but remember you don't have to answer any question if you choose not to.

Sponsored by the Institute of Indigenous Peoples Health
Canadian Institutes of Health Research

Interview Date: Month_____; Day_____; Year_____

Interviewer ID: _____
Household ID: _____
Person ID: _____

A. GENERAL INFORMATION

This section is about general information about you and your home.

A-1. What is your age? _____years

A-2. Date of Birth: Month____ Year ____

A-3. Sex?
- ☐ Male
- ☐ Female

A-4. Height _____cm/inches A-5. Weight _____Lbs/Kg A-6. Neck circumference _____cm

A-7. Highest level of education?
- ☐ Grade 8 or less
- ☐ Did not complete high school
- ☐ Completed high school
- ☐ Some University
- ☐ Completed University
- ☐ Completed technical school

A-8. Employment status at this time? (check all that apply)
- ☐ Employed full time
- ☐ Employed part time
- ☐ Employed seasonally
- ☐ Self-employed
- ☐ Social assistance
- ☐ Unemployed
- ☐ Retired
- ☐ Homemaker
- ☐ Other (please explain)_____
- ☐ Unemployment insurance

If not currently working, skip to Question A-11.

A-9. What is your current job? _____

A-10. Are you a shift worker?
- ☐ Yes
- ☐ No

A-11. Was any part of your body injured during **the past year** (off usual activities for at least 4 hours or seen by a doctor or nurse for injury)?
- ☐ Yes
- ☐ No

If YES, please answer the following questions. If NO skip to Question A-12.

a. How many times were you injured during the last year? _____

b. What body parts? _____

If you had more than one injury, please think about your most serious injury and answer following:

c. What caused the injury?

- ☐ Motor vehicle accident
- ☐ ATV accident
- ☐ Snowmobile accident
- ☐ Boating accident
- ☐ Hunting accident
- ☐ Contact with a machine, tool, etc.
- ☐ Hit by another person
- ☐ Other (Specify):

A-12. Did you attend a residential school?

- ☐ Yes
- ☐ No

A-13. Did either of your parents or grandparents attend a residential school?

- ☐ Yes
- ☐ No
- ☐ Do not know

A-14. At the end of the month, how much money do you have left over? 

- ☐ Some money
- ☐ Just enough money
- ☐ Not enough money

A-15. In general would you say your _____ health is:

	Excellent	Very Good	Good	Fair	Poor
Physical health	☐	☐	☐	☐	☐
Mental health	☐	☐	☐	☐	☐
Emotional health	☐	☐	☐	☐	☐
Spiritual health	☐	☐	☐	☐	☐

HOUSE YOU LIVED IN MOST. 

A-16. How many houses did you live in during the past year? Circle one

1 2 3 4 5 More than 5

The following questions are about <u>the house</u> that you lived in <u>most</u> during the last year.

A-17. The house number of the house you lived in the most? _____

A-18. How many people lived in the house? _____

A-19. How many rooms were in the house? _____rooms
(Do not count bathrooms, halls, laundry rooms and attached sheds)

A-20. How many bedrooms were in the house? _____

A-15b. How many beds were in the house?_____

A-21. Where did you sleep in the house? 

- ☐ Bedroom
- ☐ Living room
- ☐ Basement
- ☐ Other

A-22. What did you sleep on in the house?

- ☐ Bed
- ☐ Couch/Sofa
- ☐ Floor
- ☐ Other

A-22a. Who else shared that sleeping arrangements?

- ☐ Child
- ☐ Spouse or partner
- ☐ Alone
- ☐ Other (family members etc.)

A-23. Does your house have any damage caused by dampness (such as wet spots on walls, floors)?

- ☐ Yes
- ☐ No

A-24. Does your house (including basement) often have a moldy or musty smell?

- ☐ Yes
- ☐ No

A-25. Are there signs of mold in any living areas in your house?

- ☐ Yes
- ☐ No

A-26. Do people regularly smoke in your house?

- ☐ Yes
- ☐ No

HEALTH CARE

A-27. Do you have access to the following health care professionals? (check all that apply)

	Yes	No
Doctor off reserve	☐	☐
Doctor at clinic on reserve	☐	☐
Nurse	☐	☐

A28. Did you ever experience any difficulty getting to see a medical specialist care you needed for a diagnosis or consultation?

- ☐ Yes
- ☐ No

B.SLEEP

B-1. On average, how often do you get out of bed during the night?

- ☐ Never
- ☐ 1-2 times
- ☐ 3 or more times

B-2. If you get out of bed at night, how long does it usually take you to fall back asleep? _____minutes

B-3. How many days per week do you have trouble going to sleep or staying asleep?

- ☐ 0 days
- ☐ 1 day
- ☐ 2 days
- ☐ 3 days
- ☐ 4 days
- ☐ 5 days
- ☐ 6 days
- ☐ 7 days

B4. At what time of year do you …. (Check all that apply)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	None
A. Sleep least													
B. Sleep most													

B5. How much your sleep change with the seasons?

0 No change 1 2 3 4 Extremely marked change

B6. Approximately how many hours of each 24-hour day do you sleep each season?

	Hours of slept per day											
	0	1	2	3	4	5	6	7	8	9	10	Over 10 hours
Winter												
Spring												
Summer												
Fall												

B-7. What prevents you from having a good sleep? (check all that apply)

	Yes	No
Physical discomfort	☐	☐
Bed type	☐	☐
Noise in house	☐	☐
Stress	☐	☐
Anxiety/worry	☐	☐
Cell phone/texting	☐	☐
Other _____	☐	☐

B-8. Are you afraid to sleep?

- ☐ Yes
- ☐ No

B-14a. If Yes, what are the reasons? _____

B-9. Do you feel safe in your home when you sleep?

- ☐ Yes
- ☐ No

B-7a. If No, what are the reasons? _____

B-10. What kind of dreams do you usually have?

- ☐ Pleasant
- ☐ Disturbing
- ☐ Uninteresting
- ☐ None
- ☐ Don't remember

B-11. Do you wake up during the night due to terrifying dreams or nightmares or flashback to a traumatic event (bad experience)?

- ☐ Yes
- ☐ No

B-9a. If yes, how often does this occur?

- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Less than 1 time a month

This next question is about daytime sleepiness.

B-10.EPWORTH SLEEPINESS SCALE.

Over the past month, how likely are you to doze off or fall asleep in the following situation(s), in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
a. Sitting and reading	☐	☐	☐	☐
b. Watching TV	☐	☐	☐	☐
c. Sitting, inactive in public place (e.g. theatre or meeting)	☐	☐	☐	☐
d. As a passenger in a car for an hour without a break	☐	☐	☐	☐
e. Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
f. Sitting down and talking to someone	☐	☐	☐	☐
g. Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
h. In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

	Yes	No
B-11. Do you snore?	☐	☐
B-12. Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	☐	☐
B-13. Do you often feel TIRED, fatigued, or sleepy during daytime?	☐	☐
B-14. Has anyone OBSERVED you stop breathing during your sleep?	☐	☐

The next questions are about difficulty falling or stay asleep.
Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
B-15. Difficulty falling asleep	☐	☐	☐	☐	☐
B-16. Difficulty staying asleep	☐	☐	☐	☐	☐
B-17. Problems waking up too early	☐	☐	☐	☐	☐

B-18. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

☐ Very Satisfied ☐ Satisfied ☐ Moderately Satisfied ☐ Dissatisfied ☐ Very Dissatisfied

B-19. 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

B-20. How WORRIED/DISTRESSED are you about your current sleep problem?

☐ Not at all Worried ☐ A Little ☐ Somewhat ☐ Much ☐ Very Much Worried

B-21. 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, etc.) CURRENTLY?

☐ Not at all Interfering ☐ A Little ☐ Somewhat ☐ Much ☐ Very Much Interfering

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The following questions are about your usual sleep habits during the past month only. Your answers should indicate the most correct reply for most of days and nights in the past month. Please answer all questions.

During the past month,

B-22. What time have you usually gone to bed? _____

B-23. How long (in minutes) has it taken you to fall asleep each night? _____

B-24. What time have you usually gotten up in the morning? _____

B-25. How many hours of actual sleep do estimate you get at night?

(This may be different than the number of hours you spend in bed) _____

B-26. During the past month, how often have you had trouble sleeping because you:

	Not during the past month	Less than once per week	Once or twice per week	Three or more times per week
a. Cannot get to sleep within 30 minutes	☐	☐	☐	☐
b. Wake up in the middle of the night or early morning	☐	☐	☐	☐
c. Have to get up to use the bathroom	☐	☐	☐	☐
d. Cannot breathe comfortably	☐	☐	☐	☐
e. Cough or snore loudly	☐	☐	☐	☐
f. Feel too cold	☐	☐	☐	☐
g. Feel hot	☐	☐	☐	☐
h. Have bad dreams	☐	☐	☐	☐
i. Have pain	☐	☐	☐	☐
j. Other reason(s):_____	☐	☐	☐	☐
B-27. During the past month, how often have you taken medicine (prescribed or over the counter) to help you sleep?	☐	☐	☐	☐

B-28. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?	☐	☐	☐	☐
B-29. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?	☐	☐	☐	☐

B-30. During the past month, how would you rate your sleep quality overall?

- ☐ Very Good
- ☐ Fairly good
- ☐ Fairly bad
- ☐ Very Bad

THANK YOU SO MUCH FOR YOUR PATIENCE.

WE ARE OVER HALF DONE THIS QUESTIONNAIRE.

THE NEXT TWO SECTIONS ARE ABOUT YOUR MEDICAL HISTORY AND LIFESTYLE.

C.MEDICAL HISTORY

The next group of questions are about your medical history.

C-1. Has a doctor or nurse practitioner ever said you had?:

	Yes	No	Do not know	Do you take medication for this condition	
				Yes	No
High blood pressure	☐	☐	☐	☐	☐
Heart problems (angina, myocardial infarction, heart attack, heart failure)	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
High cholesterol and/or triglycerides	☐	☐	☐		☐
Diabetes	☐	☐	☐		☐
Atrial fibrillation	☐	☐	☐	☐	
Chronic obstructive pulmonary disease (COPD)/ Emphysema	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Chronic bronchitis	☐	☐	☐	☐	☐
Pneumonia	☐	☐	☐	☐	☐
Acid coming up from your stomach into your throat (Reflux/Heartburn)	☐	☐	☐	☐	☐
Low thyroid hormone levels	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Severe eyesight problems	☐	☐	☐	☐	☐
Sinus problems	☐	☐	☐	☐	☐
Parkinson's disease	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐		☐
Post-Traumatic Stress Disorder (PTSD)	☐	☐	☐	☐	☐
Chronic pain	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐
Unpleasant discomfort in your legs: creepy crawly, or tingly feeling in your legs combined with an urge or need to move your legs)	☐	☐	☐	☐	☐
a. If Yes, do these feelings (discomfort, creepy crawly, or tingly feeling) occur mainly or only at bed time?	☐	☐	☐		

The next questions are about the medications that you take.

C-2. Are you taking any prescription medication on a regular basis?

- ☐ Yes
- ☐ No

C-3. Are you taking medicines used for sleep (melatonin, valerian root, Zopiclone etc.)?

- ☐ Yes
- ☐ No

C-4. Are you taking traditional medicines used for sleep?

- ☐ Yes
- ☐ No

D. LIFESTYLE

These next questions are about your lifestyle related to smoking, alcohol use, recreational drug use, caffeine use and exercise.
Smoking

D-1. Have you ever smoked cigarettes?
"No" means less than 20 packs in a lifetime or less than one cigarette per day for a year.

- ☐ Yes
- ☐ No ***If NO, go to questions D-2.***

If YES answer the following questions.

D-1a. Do you currently smoke cigarettes?

- ☐ Yes
- ☐ No

D-1b. How many cigarettes do you smoke per day? _____cigarettes per day

D-1c. How old were you when first started regular cigarette smoking? _____years old

D-1d. On average, over the entire time you have smoked, how many cigarettes have/did you smoke each day? _____cigarettes per day

D-1e. If you have stopped smoking cigarettes completely, how many years ago did you stop smoking cigarettes? _____years

D-1f. If there have been periods when you stopped smoking, indicate the total number of years that you were free from cigarettes smoking. _____years

D-2. Do you smoke tobacco for ceremonial purpose?

- ☐ Yes
- ☐ No

The next group of questions are about alcohol use.

D-3. In a typical week during the past year, how many days per week do you have an alcoholic drink? _____

If Do not drink alcohol, go to questions D-5.

D-3a. On days when you drink alcohol, how many standard drinks of alcohol do you think you would have? _____(Drinks per day)

D-4. Do you drink alcohol within two hours of going to bed?

- ☐ Yes
- ☐ No

The next group of questions are about recreational drug use.

D-5. Are you taking marijuana?

- ☐ Regularly
- ☐ Occasionally
- ☐ No

D-6. Are you taking other non-medical drugs?

- ☐ Yes
- ☐ No

The next questions are about caffeine use.

D-7. How many cups of beverages do you drink per day on average?

Beverages	How many cups of beverages do you drink per day on average?			
	None	1 per day	2-5 per day	More than 5 per day
Caffeinated (tea, coffee, coke, pepsi etc.)	☐	☐	☐	☐
Non-caffeinated drinks	☐	☐	☐	☐
Energy drinks (Monster, red bull etc.)	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

D-8. Do you drink caffeinated beverages within two hours going to bed?

- ☐ Yes
- ☐ No

The next questions are about your physical activity.

D-9. In a typical week during the past year, how many days per week do you usually exercise (including walking, biking etc.)? _____days (i.e. none, 1, 2, 3, ...,7)

D-10. How long do you usually exercise?

- ☐ Never
- ☐ Less than 30 minutes
- ☐ 30 or more minutes

D-11. Did you gain 10 or more pounds of weight in the last year?

- ☐ Yes
- ☐ No

D-11a. If yes, how much did you gain?

- ☐ 10-15 pounds
- ☐ 16-30 pounds
- ☐ More than 31 pounds

D-12. How many hours per day spend on screen time (a phone, computer or other mobile devices including playing computer or video games and using the internet (social media etc.), or Web)?

0 1 2 3 4 5 6 7 8 8+ hours

D-13. In a typical week in the past 3 months, how much time did you usually spend watching television or videos?

0 1 2 3 4 5 6 7 8 8+ hours

D-14.How many minutes/hours before bedtime you stop screen time?

- ☐ < 15 minutes
- ☐ 15 minutes
- ☐ 1 hour
- ☐ 2 hours
- ☐ More than 2 hours

The next questions are about Post-Traumatic Stress Disorder (PTSD)

D-14. In the past week....

	Not at all	A little bit	Moderately	Quite a lot	Very much
a. How much have you been bothered by unwanted memories, nightmares or reminders of the event?	☐	☐	☐	☐	☐
b. How much effort have you made to avoid thinking or talking about the event, or doing things, which remind you of what happened?	☐	☐	☐	☐	☐
c. To what extent have you lost enjoyment for things, kept your distance from people, or found it difficult to experience feelings?	☐	☐	☐	☐	☐
d. How much have you been bothered by poor sleep, poor concentration, jumpiness, irritability or feeling watchful around you?	☐	☐	☐	☐	☐
e. How much have you been bothered by pain, aches, or tiredness?	☐	☐	☐	☐	☐
f. How much would you get upset when stressful events or setbacks happen to you?	☐	☐	☐	☐	☐
g. How much have the above symptoms interfered with your ability to work or carry out daily activities?	☐	☐	☐	☐	☐
h. How much have the above symptoms interfered with your relationships with family or friends?	☐	☐	☐	☐	☐

Other Comments: (Please use back of page if more room is needed).

THIS IS THE END OF THE SURVEY. THANK YOU VERY MUCH FOR YOUR HELP!

CONTACT INFORMATION

Name: _____
(Name of person completing the survey)

Age: _____ □ Male □ Female

_____

Address (Post office box and street address)

_____, _____

Town Postal code

_____

Home Reserve House number

Telephone Numbers **(check most preferred):**

Work _____ □

House _____ □

Cell _____ □

Family Physician's Name: _____

Family Physician's Phone Number: _____