Demographic Questionnaire - HRV Psychophysiological Experiment

Please answer the questions honestly. Your answers will remain anonymous.

**Gender:** Male / Female **Age:** \_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
|  | **YES**  **NO** |
| 1. Have you rushed in order to arrive on time for this experiment?
 |  ❒ ❒ |
| 1. Have you taken part in any intensive physical activity in the past 24 hours? If yes please describe activity type and length.
 |  ❒ ❒ |
| 1. When was the last time you exercised?
 |  |
| 1. Have you eaten in the past two hours?
 |  ❒ ❒ |
| 1. Have you consumed any caffeine/theine-containing beverages in the past two hours?
 |  ❒ ❒ |
| 1. Have you consumed any alcoholic beverages in the past 24 hours?
 |  ❒ ❒ |
| 1. Do you usually smoke?

 If yes, please report the number of cigarettes you smoke on a daily basis. |  ❒ ❒\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you smoked in the past two hours?
 |  ❒ ❒ |
| 1. Do you currently take any medication?

If yes, please write down the name of the medication/s. |  ❒ ❒\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. For female participants, are you taking a form of oral contraceptive?
 |  ❒ ❒ |
| 1. Do you have any known blood pressure conditions?
 |  ❒ ❒ |
| 1. Did you follow your usual sleep routine last night?
 |  ❒ ❒ |
| 1. When did you get up this morning?
 |  |
| 1. When did you go to sleep last night?
 |  |
| 1. Do you suffer from any mental disorders, for example severe depression or anxiety disorder?
 |  ❒ ❒ |
| 1. Do you have any chronic heart issues or respiratory conditions?
 |  ❒ ❒ |
| 1. Do you need to use the bathroom?
 |  ❒ ❒ |

Height: \_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_

Hips measurement: \_\_\_\_\_\_\_\_\_\_\_\_ Waist measurement: \_\_\_\_\_\_\_\_\_\_\_\_