



Sample 3: (About 4 hours after you wake up)

A.) ACTUAL TIME SAMPLE TAKEN	B.) BEFORE TAKING THIS SAMPLE, DID YOU DO ANY OF THE FOLLOWING?	C.) DO YOU FEEL HAPPY, EXCITED, OR CONTENT RIGHT NOW?	D.) DO YOU FEEL WORRIED, ANXIOUS, OR FEARFUL RIGHT NOW?	E.) PROBLEMS OR CONCERNS?
<input type="text"/> : <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM	<input type="radio"/> Brushed teeth? <input type="radio"/> Eaten anything? <input type="radio"/> Drunk anything? <input type="radio"/> Exercised?	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Very much <input type="radio"/> Extremely	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Very much <input type="radio"/> Extremely	



Sample 4: (About 10 hours after you wake up)

A.) ACTUAL TIME SAMPLE TAKEN	B.) BEFORE TAKING THIS SAMPLE, DID YOU DO ANY OF THE FOLLOWING?	C.) DO YOU FEEL HAPPY, EXCITED, OR CONTENT RIGHT NOW?	D.) DO YOU FEEL WORRIED, ANXIOUS, OR FEARFUL RIGHT NOW?	E.) PROBLEMS OR CONCERNS?
<input type="text"/> : <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM	<input type="radio"/> Brushed teeth? <input type="radio"/> Eaten anything? <input type="radio"/> Drunk anything? <input type="radio"/> Exercised?	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Very much <input type="radio"/> Extremely	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Very much <input type="radio"/> Extremely	



Sample 5: (Before bed and BEFORE brushing!)

A.) ACTUAL TIME SAMPLE TAKEN	B.) BEFORE TAKING THIS SAMPLE, DID YOU DO ANY OF THE FOLLOWING?	C.) DO YOU FEEL HAPPY, EXCITED, OR CONTENT RIGHT NOW?	D.) DO YOU FEEL WORRIED, ANXIOUS, OR FEARFUL RIGHT NOW?	E.) PROBLEMS OR CONCERNS?
<input type="text"/> : <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM	<input type="radio"/> Brushed teeth? <input type="radio"/> Eaten anything? <input type="radio"/> Drunk anything? <input type="radio"/> Exercised?	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Very much <input type="radio"/> Extremely	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Very much <input type="radio"/> Extremely	

ADDITIONAL QUESTIONS FOR END OF DAY:

1. DID YOU SMOKE ANY CIGARETTES? No Yes → **HOW MANY CIGARETTES DID YOU SMOKE TODAY?**

2. DID YOU DRINK ANY ALCOHOLIC BEVERAGES TODAY?? No Yes

3. DID YOU TAKE ANY DRUGS OR MEDICATIONS TODAY? No Yes → **PLEASE LIST THE NAMES OF ALL DRUGS OR MEDICATIONS YOU TOOK TODAY:**

4. DID YOU DO ANY VIGOROUS EXERCISE TODAY, EXERCISE THAT INCREASED YOUR HEART RATE OR MADE YOU SWEAT?
 Yes → **WHAT TIME DID IT BEGIN?** : AM PM **HOW LONG DID YOU EXERCISE FOR?** MINUTES
 No

Public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0626). Do not return the completed form to this address.

Place Saliva Log PID Barcode Label here

Date of Samples / /
 Month Day Year



Sample 1: (Please take sample while still in bed!)

A.) ACTUAL TIME SAMPLE TAKEN	B.) BEFORE TAKING THIS SAMPLE, DID YOU DO ANY OF THE FOLLOWING?	C.) DO YOU FEEL HAPPY, EXCITED, OR CONTENT RIGHT NOW?	D.) DO YOU FEEL WORRIED, ANXIOUS, OR FEARFUL RIGHT NOW?	E.) PROBLEMS OR CONCERNS?
<input type="text"/> : <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM	<input type="radio"/> Brushed teeth? <input type="radio"/> Eaten anything? <input type="radio"/> Drunk anything? <input type="radio"/> Exercised?	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Very much <input type="radio"/> Extremely	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Very much <input type="radio"/> Extremely	

ADDITIONAL QUESTIONS FOR BEGINNING OF DAY:

1. AROUND WHAT TIME DID YOU FALL ASLEEP LAST NIGHT? : AM PM

2. WHAT TIME DO YOU USUALLY WAKE UP? : AM PM

3. WHAT TIME DID YOU WAKE UP TODAY? : AM PM

4. HOW MANY TIMES DID YOU WAKE UP LAST NIGHT? Times

5. HOW MANY HOURS AND MINUTES OF SLEEP DID YOU GET LAST NIGHT? Hrs : Mins

6. HOW MANY HOURS AND MINUTES OF SLEEP DO YOU USUALLY GET A NIGHT? Hrs : Mins

PLEASE NOTE: Take the next sample 45 minutes after the first. It is fine to brush your teeth and eat your breakfast in the first 25 minutes after taking sample 1, but please avoid doing these in the 20 minutes right before taking sample 2. Please avoid ALL caffeinated beverages until AFTER you have taken sample 2.



Sample 2: (45 minutes after you wake up)

A.) ACTUAL TIME SAMPLE TAKEN	B.) BEFORE TAKING THIS SAMPLE, DID YOU DO ANY OF THE FOLLOWING?	C.) DO YOU FEEL HAPPY, EXCITED, OR CONTENT RIGHT NOW?	D.) DO YOU FEEL WORRIED, ANXIOUS, OR FEARFUL RIGHT NOW?	E.) PROBLEMS OR CONCERNS?
<input type="text"/> : <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM	<input type="radio"/> Brushed teeth? <input type="radio"/> Eaten anything? <input type="radio"/> Drunk anything? <input type="radio"/> Exercised?	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Very much <input type="radio"/> Extremely	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Very much <input type="radio"/> Extremely	



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Sample 4: (About 10 hours after you wake up)

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Sample 5: (Before bed and BEFORE brushing!)

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ADDITIONAL QUESTIONS FOR END OF DAY:

1. DID YOU SMOKE ANY CIGARETTES? No YES → **How many cigarettes did you smoke today?**

2. DID YOU DRINK ANY ALCOHOLIC BEVERAGES TODAY?? No YES

3. DID YOU TAKE ANY DRUGS OR MEDICATIONS TODAY?
 No YES → **PLEASE LIST THE NAMES OF ALL DRUGS OR MEDICATIONS YOU TOOK TODAY:** _____

4. DID YOU DO ANY VIGOROUS EXERCISE TODAY, EXERCISE THAT INCREASED YOUR HEART RATE OR MADE YOU SWEAT?
 YES → **WHAT TIME DID IT BEGIN?** : AM PM **HOW LONG DID YOU EXERCISE FOR?** MINUTES
 No

Date of Samples / /
 Month Day Year



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<input type="text"/> : <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM	<input type="radio"/> Brushed teeth? <input type="radio"/> Eaten anything? <input type="radio"/> Drunk anything? <input type="radio"/> Exercised?	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Very much <input type="radio"/> Extremely	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Very much <input type="radio"/> Extremely	

Now that you have taken sample 2, it is fine to drink coffee.

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