Supplementary file 2

Increasingly, many people living with traumatic brain injury have been concerned with recovery and post-injury health, which may be influenced by disparities in access to, and quality of health care, and differing risks for adverse outcomes across groups of people, which are often shaped by gender-related inequalities. Our research aims to understand influences of gender in traumatic brain injury and examine the impact of sex and gender on knowledge translation interventions.

We ask you to please complete this questionnaire to the best of your ability. It is very important that you answer every question. If some questions are difficult to answer, please use the help of a "significant other". A significant other is *a person with whom you feel closest.* This includes anyone that you can relate to on a regular or infrequent basis. If you have no one to help you, please seek help from the research team members.

LET'S START
(see next page)

DEMOGRAPHICS

1) At what time of day are you beginning this questionnaire? (please be specific; circle a.m. or p.m.) _____ a.m. / p.m.

2) What sex were you assigned at birth, meaning on your original birth certificate?
   - ☐ Male
   - ☐ Female

3) What is your current gender identity?
   - ☐ Man
   - ☐ Woman
   - ☐ Trans man
   - ☐ Trans woman
   - ☐ Gender queer/ gender non-conforming
   - ☐ Different identity (please specify) _____

4) What is your age? _____ years

5) What is your highest level of education?
   - ☐ Did not complete secondary / high school diploma
   - ☐ Secondary (high) school graduation certificate/ diploma or equivalent
   - ☐ High school diploma and some post-secondary education (college, trades school, university) certificate or diploma below a bachelor's level
   - ☐ Bachelor's Degree
   - ☐ University certificate or diploma above Bachelor's level
   - ☐ Advanced degree (i.e. Masters, PhD/doctorate, medicine, dentistry)
   - ☐ Other (please specify)_____

6) What is your ethnicity?
   - ☐ Aboriginal
   - ☐ British origin
   - ☐ French origin
   - ☐ European
   - ☐ Latino
   - ☐ African
   - ☐ Arab
   - ☐ Chinese
   - ☐ East & South East Asia
   - ☐ Other (please specify)_____

7) What is your current marital status?
   - ☐ Never married
   - ☐ Married/living with someone/common law
   - ☐ Divorced/separated
   - ☐ Widowed
   - ☐ Other (please specify)_____

FAMILY AND HOME LIFE

8) How many dependent children do you have in your home? _____

9) How would you rate your experiences with access to family support? (1= limited access, 6 = significant access)

	1	2	3	4	5	6	
Limited Access							**Significant Access**

10) Please expand on your experiences:

_____
_____
_____
_____

11) Do you have access to suitable and accessible housing?

- ☐ Yes
- ☐ No

HOSPITAL AND HEALTH CARE

12) In the past 5 years, approximately how many times have you gone to the emergency department or have been admitted ?

_____

13) How would you rate your experiences within a clinical setting (i.e., hospital)? (1= Negative, 6 = Positive)

1	2	3	4	5	6
Negative					**Positive**

14) Please expand on your experiences:

_____
_____
_____
_____

15) In the past month, approximately how many times have you visited a doctor?

_____

16) How many minutes did you wait (on average, if multiple visits) in the waiting room before seeing the doctor?

- ☐ Less than 10 minutes
- ☐ 11-20 minutes
- ☐ 21-30 minutes
- ☐ More than 30 minutes

17) Over the past 12 months, have you sustained a brain injury?

- ☐ Yes
- ☐ No

18) If yes to the above question, what event led to the injury (i.e., assault, motor vehicle accident; be specific)

_____
_____
_____

19) If you answered yes to question 17, do you feel that you have sufficient knowledge or skills to cope with your brain injury?

- ☐ Yes
- ☐ No

20) If you have a brain injury, please describe how the health care system has supported or hindered (or both) your ability to cope with brain injury:

_____
_____
_____
_____

WORK RESPONSIBILITIES

21) What is your current work status?

- ☐ Full-time
- ☐ Part-time, or less than full-time
- ☐ Not employed
- ☐ On disability

22) If employed, what is your job title? _____

23) If employed, please describe your duties:

_____
_____
_____
_____

24) If employed do you perform shift work (i.e., outside of the traditional 9:00am – 5:00pm day)?

- ☐ Yes
- ☐ No

25) If yes, please describe your shift:

_____
_____
_____

_____

26) Did you perform shift work within the last 12 months (i.e., outside of the traditional 9:00am – 5:00pm day)?

- ☐ Yes
- ☐ No

27) If yes, please describe your shift:

_____

_____

_____

HEALTH BEHAVIORS

28) On average, how much alcohol do you consume per day (if less than 1 drink per day, enter 0)?

Can(s) of Beer # _____

Glass(es) of Wine # _____

Ounce(s) of Liquor # _____

Other alcoholic beverages # _____

29) On average, how much caffeine do you intake each day?

Cup(s) of Coffee # _____

Cup(s) of Tea # _____

Can(s) of Cola # _____

Other stimulating drinks # (be specific)

_____

30) Do you use recreational drugs?

- ☐ Yes
- ☐ No

31) If you answered yes to the previous question, please specify the drug(s):

_____

32) Please identify if you have any of the following: (Circle ALL that apply)

1. Arthritis (chronic stiffness or pain in joints)	No	Yes
2. Depression/ Anxiety	No	Yes
3. Diabetes	No	Yes
4. Pain disorder	No	Yes
5. Head Trauma	No	Yes
6. Heart Disease	No	Yes
7. Liver Disease	No	Yes
8. Cancer	No	Yes
9. Parkinson Disease	No	Yes
10. Infectious Diseases	No	Yes
11. Kidney Disease	No	Yes
12. Seizure	No	Yes
13. Stroke	No	Yes
14. Other (be specific)_____ _____ _____	No	Yes

MASCULINITY/FEMININITY SCALE

On a scale of 0 (not at all) to 9 (very), please indicate:

1. How **feminine** do you consider yourself to be compared to the whole population (**men AND women**)? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9

2. How **masculine** do you consider yourself to be compared to the whole population (**men AND women**)? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9

3. How **feminine** do you consider yourself to be compared to (other) **men**?
   0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9

4. How **masculine** do you consider yourself to be compared to (other) **men**?
   0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9

5. How **feminine** do you consider yourself to be compared to (other) **women**?
   0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9

6. How **masculine** do you consider yourself to be compared to (other) **women**?
   0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9

KINSEY'S SEXUAL ORIENTATION SCALE

Where would you put yourself along sexual orientation scale: from exclusively straight to exclusively gay ("i.e., heterosexual or homosexual")? **Note:** Indicate where you think your sexual orientation or identity is, regardless of <u>actual</u> sexual experience.

____ Exclusively heterosexual

____ Heterosexual with incidence homosexual

____ Heterosexual with substantial homosexual

____ Equal heterosexual/homosexual

____ Other

____ Homosexual w substantial heterosexual

____ Homosexual w incidental heterosexual

____ Exclusively homosexual

____ Asexual

Community Integration Questionnaire

Answer (circle one)

Home Integration	
1. Who usually does shopping for groceries or other necessities in your household?	Yourself alone (2) Yourself and someone else (1) Someone else (0)
2. Who usually prepares meals in your household?	Yourself alone (2) Yourself and someone else (1) Someone else (0)
3. In your home who usually does normal everyday housework?	Yourself alone (2) Yourself and someone else (1) Someone else (0)
4. Who usually cares for the children in your home?	Yourself alone (2) Yourself and someone else (1) Someone else (0) Not applicable (score is the average of 1,2,3 and 5)
5. Who usually plans social arrangements such as get-togethers with family and friends?	Yourself alone (2) Yourself and someone else (1) Someone else (0)
Social Integration	
6. Who usually looks after your personal finances such as banking or paying bills?	Yourself alone (2) Yourself and someone else (1) Someone else (0)
Approximately how many times a month you now usually participate in the following activities outside your home?	
7. Shopping	5 or more (2) 1 – 4 times (1) Never (0)
8. Leisure activities such as movies, sports, restaurants	5 or more (2) 1 – 4 times (1) Never (0)
9. Visiting friends or relatives	5 or more (2) 1 – 4 times (1) Never (0)
Integration into Productive Activities	
12. How often do you travel outside the home?	almost every day (2) almost every week (1) seldom/never (less than once per week) (0)

13. Please choose the answer below that best corresponds to your current (during the past month) work situation:	Full-time employment (>20 hours/week) Part Time Employment (< 20 hours/week) Not working, but actively looking for work Not working, not looking for work Not applicable, retired due to age Volunteer job in the community
14. Please choose the answer below that best corresponds to your current (during the past month) school or training program	Full-time Part-time Not attending school or training program
15. In the past month, how often did you engage in volunteer activities?	5 or more 1 – 4 times Never

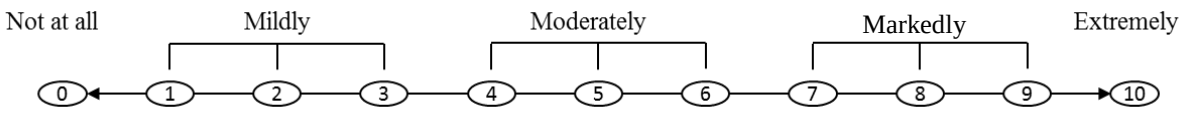
TOTAL SCORE

Sheehan Disability Scale Questionnaire

Please mark ONE circle for each scale

WORK*

The symptoms have disrupted your work:

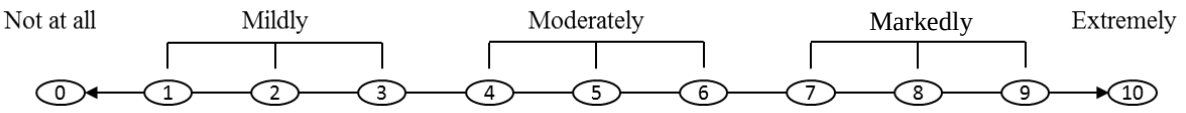


☐ I have not worked at all during the past week for reasons unrelated to the disorder

*Work includes paid, unpaid volunteer work or training

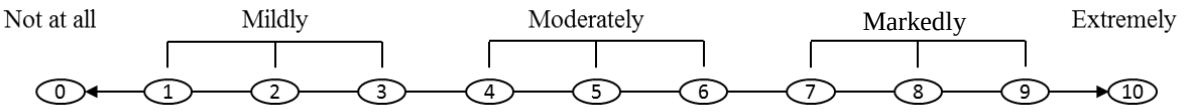
SOCIAL LIFE

The symptoms have disrupted your social life / leisure activities:



FAMILY LIFE / HOME RESPONSIBILITIES

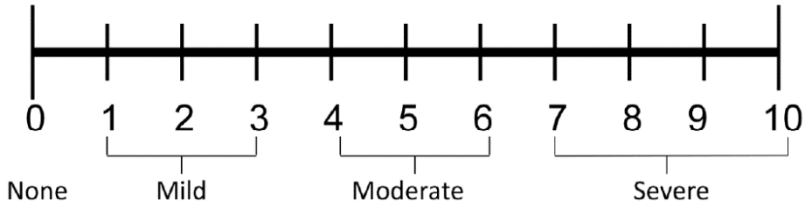
The symptoms have disrupted your family life / home responsibilities:



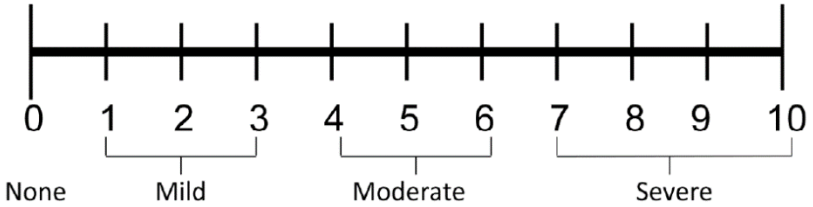
THE NUMERIC PAIN RATING SCALE

Please indicate the intensity of **current**, **best**, and **worst** pain levels over the past 24 hours on a scale of 0 (no pain) to 10 (worst pain imaginable)

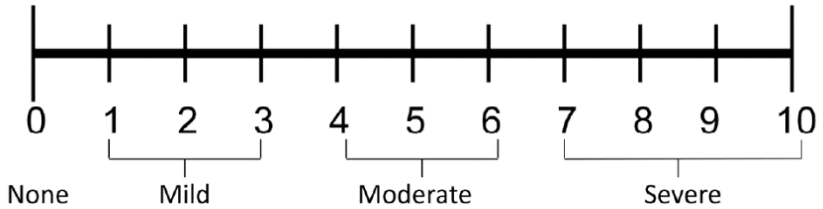
Current level of pain



Best Level of pain



Worst Level of Pain



TOTAL SCORE

PATIENT HEALTH QUESTIONNAIRE

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people

Not at all difficult	Somewhat difficult	Difficult	Extremely difficult
0	1	2	3

TOTAL SCORE

MENTAL HEALTH ATTITUDES QUESTIONNAIRE

Please read each statement and circle a number from 1 to 7, depending on how appropriate you feel the statement applies to you over the preceding week. A low value indicates that the statement is not very appropriate whereas a high value indicates agreement.

	Completely disagree			Neutral			Completely agree
1. There are effective medications that allow people with mental health problems to return to normal and productive lives	1	2	3	4	5	6	7
2. I don't think that it is possible to have a normal relationship with someone with mental health problems	1	2	3	4	5	6	7
3. I would find it difficult to trust someone with mental health problems	1	2	3	4	5	6	7
4. People with mental health problems tend to neglect their appearance	1	2	3	4	5	6	7
5. I feel anxious and uncomfortable when I am around someone with mental health problems	1	2	3	4	5	6	7
6. It is easy for me to recognize the symptoms of mental health disorder	1	2	3	4	5	6	7
7. There are no effective treatment for mental health disorders	1	2	3	4	5	6	7
8. I probably would not know that someone has mental health problem unless I was told	1	2	3	4	5	6	7
9. Once someone develops mental health problems, he or she will never be able to fully recover from it	1	2	3	4	5	6	7

TOTAL SCORE

EPWORTH SLEEPINESS SCALE

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS, 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. Using the following scale, circle the most appropriate number for each situation:

0 = would NEVER doze. **Chance of dozing**: 1 = SLIGHT, 2 = MODERATE, 3 = HIGH

SITUATION	CHANCE OF DOZING			
1. Sitting and reading	0	1	2	3
2. Watching TV	0	1	2	3
3. Sitting, inactive in a public place (e.g. a theatre or a meeting)	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon when circumstances permit	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after a lunch without alcohol	0	1	2	3
8. In a car, while stopped for a few minutes in the traffic	0	1	2	3

TOTAL SCORE

FATIGUE SEVERITY SCALE

Please read each statement and circle a number from 1 to 7, depending on how appropriate you feel the statement applies to you over the preceding week. A low value indicates that the statement is not very appropriate whereas a high value indicates agreement.

During the past week, I have found that:	Score
1. My motivation is lower when I am fatigued	1 2 3 4 5 6 7
2. Exercise brings on my fatigue	1 2 3 4 5 6 7
3. I am easily fatigued	1 2 3 4 5 6 7
4. Fatigue interferes with my physical functioning	1 2 3 4 5 6 7
5. Fatigue causes frequent problems for me	1 2 3 4 5 6 7
6. My fatigue prevents sustained physical functioning	1 2 3 4 5 6 7
7. Fatigue interferes with carrying out certain duties and responsibilities	1 2 3 4 5 6 7
8. Fatigue is among my three most disabling symptoms	1 2 3 4 5 6 7
9. Fatigue interferes with my work, family, or social life	1 2 3 4 5 6 7

TOTAL SCORE

TORONTO HOSPITAL ALERTNESS SCALE

This questionnaire tries to establish how alert you feel. In reporting your feeling, we would like you to consider your last week. Using the following scale, please choose one response for each question.

During the last week I felt:	Not at all	Less than ¼ of the time	¼ to ½ of the time	½ to ¾ of the time	More than ¾ of the time	All the time I was awake
1. Able to concentrate						
2. Alert						
3. Fresh						
4. Energetic						
5. Able to think of new ideas						
6. Vision was clear noting all details (e.g., driving)						
7. Able to focus on the task at hand						
8. Mental facilities were operating at peak level						
9. Extra effort was needed to maintain alertness						
10. In a boring situation, I would find my mind wondering						

SLEEP TIMING QUESTIONNAIRE SHORT (STQ-S)

This questionnaire asks about when you normally sleep. Please answer in terms of a recent "normal average week," not one in which you traveled, vacationed or had family crises.

Please think of NIGHT TIME as the time at which you are finally in bed and TRYING TO FALL ASLEEP.

On the night before a work day, what is your *earliest* NIGHT TIME?	____:____ am / pm
On the night before a work day, what is your *latest* NIGHT TIME?	____:____ am / pm
On the night before a work day, what is your *usual* NIGHT TIME?	____:____ am / pm

Please think of MORNING TIME as the time at which you finally get out of bed and start your day.

Before a work day, what is your *earliest* MORNING TIME?	____:____ am / pm
Before a work day or school day, what is your *latest* MORNING TIME?	____:____ am / pm
Before a work day or school day, what is your *usual* MORNING TIME?	____:____ am / pm

These questions are about how much sleep you lose to unwanted wakefulness:

On most nights, how long, on average does it take you to fall asleep after you start trying?	_____minutes	
On most nights, how much sleep do you lose, on average, from waking up during the night (e.g. to go to the bathroom)?	_____minutes	
Are you taking a nap more than once a week?	YES___	NO___
Are you taking sleeping pills more than once a week?	YES___	NO___

INSOMNIA SEVERITY INDEX

For each question, please CIRCLE the number that best describes your answer. Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia problem	None	Mild	Moderate	Severe	Very severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problem waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. 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
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. 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, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

TOTAL SCORE

STOP-BANG QUESTIONNAIRE

Please answer the following questions by circling the correct answer: Unknown (√)

1. Do you Snore?	Yes	No	
2. Do you feel Tired, fatigued or sleepy during the day?	Yes	No	
3. Has anyone Observed you stop breathing in your sleep?	Yes	No	
4. Do you have high blood Pressure?	Yes	No	

Your Height _____

Your Weight _____

Neck Size (in inches or centimetres) _____

TOTAL SCORE [ ]

RESTLESS LEGS QUESTIONNAIRE

1. Do you experience recurrent unpleasant sensation or tingling in your legs while sitting or lying down?	Yes	No
2. Do you repeatedly feel an urge to move your legs while sitting or lying down?	Yes	No
3. Do your legs jump or move a lot, involuntary, while sitting or lying down?	Yes	No
4. Do you have recurrent periods of time where you are so itchy, you cannot stay in one place or you have to move your arms or legs?	Yes	No

STOP here if you answered NO to all of the previous question. Continue ONLY if you answered YES to at least one of the previous questions

5. When these sensations or movements occur, are they worse while you have a rest **than** during physical activities?	Yes	No
6. If these sensation or movements are present and you begin walking, do they improve or do they disappear while you are walking?	Yes	No

STOP here if you answered NO to all of the previous question. Continue ONLY if you answered YES to at least one of the previous questions

7. If these sensations or movements are present, are they **worse** in the evening or during the night?	Evening	Night
8. Not NOW, but when these sensations or movements started, were these sensations or movements **worse** in the evening or during the night?	Evening	Night

TOTAL SCORE

At what time of day have you completed this questionnaire? (Please be specific; circle a.m. or p.m.) _____ a.m. / p.m.

Thank you for taking the time to fill out this questionnaire. Your participation supports the advancement of gender-sensitive approaches to traumatic brain injury. Please submit your completed questionnaire to a member of the research team.