**ADDITIONAL FILE 1**

Impact of Side effects on functioning and emotion Survey Items (programmed via a web survey)

**A. SLEEPINESS**

[SKIP IF “NEVER” SELECTED FOR ITEM 1 OF GASS]

1. You have said that since taking your current medication, you have felt sleepy during the day. When did you last experience the feeling of being sleepy during the day?
   
   O₁ In the past day  
   O₂ In the past week  
   O₃ In the past month  
   O₄ In the past 3 months  
   O₅ In the past year

2. Has this feeling of sleepiness during the day been affecting your energy level?
   
   O₁ Yes O₂ No

   [SHOW IF YES] Please indicate on the scale; how much has sleepiness during the day affected your energy level? (To enter your response below, click on the circle and drag it to the left or right to show how much your energy level was affected)

3. Has this feeling of sleepiness during the day been affecting your ability to do chores around the house?
   
   O₁ Yes O₂ No
4. Has this feeling of sleepiness during the day been affecting your ability to take care of yourself?

O₁ Yes O₂ No

[SHOW IF YES] Please indicate on the scale; how much has sleepiness during the day affected your ability to take care of yourself?

<PAGE BREAK>

5. Has this feeling of sleepiness during the day been affecting you avoiding/not talking to others?

O₁ Yes O₂ No

[SHOW IF YES] Please indicate on the scale; how much has sleepiness during the day affected how much you avoid/not talk to others?

<PAGE BREAK>

6. Has this feeling of sleepiness during the day made you afraid to go out?

O₁ Yes O₂ No
Please indicate on the scale; **how much has sleepiness during the day** affected how **afraid you are to go out**?

[SHOW IF YES]

7. Has this **feeling of sleepiness during the day** made you **not be able to get a job or do your job**?

   O₁ Yes ☐₂ No

[SHOW IF YES] Please indicate on the scale; **how much has sleepiness during the day** affected your **ability to get a job or do your job**?

8. Has this **feeling of sleepiness during the day** been affecting **any other aspects of your daily functioning**?

   O₁ Yes ☐₂ No

[SHOW IF YES] Please describe the other aspect(s):

________________________________________________________

[If Yes] Please indicate on the scale; **how much has sleepiness during the day** affected **other aspects of your daily functioning**?

9. **Sleepiness during the day** has an impact on my functioning. □₁ True ☐₂ False.
10. How has this feeling sleepiness during the day made you feel? (Please check all that apply – if any)

Apathetic/Indifferent
Frustrated
Hopeless
Dissatisfied
Ashamed/Embarrassed
Trusting/Accepting
Overwhelmed
Confused/Doubtful
Impatient/Irritated/Angry
Resigned

None of the above [EXCLUSIVE]

B. RESTLESNESS

[SKIP IF “NEVER” SELECTED FOR ITEM 7 OF GASS]

1. You have said that since taking your current medication you have felt restless and you could not sit still. How long has it been since you experienced feeling restless and unable to sit still?

O1 In the past day
O2 In the past week
O3 In the past month
O4 In the past 3 months
O5 In the past year
2. Has **feeling restless and unable to sit still** been affecting your **energy level**?

   O₁ Yes O₂ No

[SHOW IF YES] Please indicate on the scale; **how much has feeling restless and not being able to sit still** affected your **energy level**? *(to enter your response below, click on the circle and drag your mouse to the left or right)*

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3. Has **feeling restless and unable to sit still** been affecting your **level of physical discomfort**?

   O₁ Yes O₂ No

[SHOW IF YES] Please indicate on the scale; **how much has feeling restless and not being able to sit still** affected your **level of physical discomfort**? *(to enter your response below, click on the circle and drag your mouse to the left or right)*

---

4. Has **feeling restless and unable to sit still** been affecting your **ability to do chores around the house**?

   O₁ Yes O₂ No

[SHOW IF YES] Please indicate on the scale; **how much has feeling restless and unable to sit still** affected your **ability to do chores around the house**?
5. Has **feeling restless and unable to sit still** been affecting **your ability to take care of yourself**?

   O₁ Yes O₂ No

   **[SHOW IF YES]** Please indicate on the scale; **how much has feeling restless and unable to sit still** affected your ability to take care of yourself?

   O₁ Very little
   O₂ A little
   O₃ Moderately
   O₄ Very Much
   O₅ Severely

5. Has **feeling restless and unable to sit still** been affecting **avoiding or not talking to others**?

   O₁ Yes O₂ No

   **[SHOW IF YES]** Please indicate on the scale, **how much has feeling restless and unable to sit still** affected how much you avoid or not talk to others?

5. Has **feeling restless and unable to sit still** been making **you afraid to going out**?

   O₁ Yes O₂ No
[SHOW IF YES] Please indicate on the scale; how much has feeling restless and unable to sit still affected how afraid you are to go out?

<PAGE BREAK>

8. Has feeling restless and unable to sit still been affecting your ability to get a job or do your job?

O1 Yes O2 No

[SHOW IF YES] Please indicate on the scale; how much has feeling restless and unable to sit still affected your ability to get a job or do your job?

<PAGE BREAK>

9. Has feeling restless and unable to sit still been affecting any other aspects of your daily functioning?

O1 Yes O2 No

[SHOW IF YES] Please describe the other aspect(s):

________________________________________________

[SHOW IF YES] Please indicate on the scale; how much has feeling restless and unable to sit still affected other aspects of your daily functioning?

<PAGE BREAK>

10. Feeling restless and unable to sit still has an impact on my functioning. □1 True □2 False

<PAGE BREAK>
11. How has **feeling restless or unable to sit still** made you feel? (Please check **all** that apply – if any)

- Apathetic/Indifferent
- Frustrated
- Hopeless
- Dissatisfied
- Ashamed/Embarrassed
- Trusting/Accepting
- Overwhelmed
- Confused/Doubtful
- Impatient/Irritated/Angry
- Resigned
- Anguished
- None of the above [EXCLUSIVE]

<PAGE BREAK>

C. TREMOR

[SKIP IF “NEVER” SELECTED FOR ITEM 6 OF GASS]

1. You have said that since taking your current medication, **your hands or arms have been shaky** (tremor). How long has it been since you experienced **your hands or arms being shaky** (tremor)?

   - O₁ In the past day
   - O₂ In the past week
   - O₃ In the past month
   - O₄ In the past 3 months
   - O₅ In the past year
2. Has this tremor been affecting your energy level?
   O₁ Yes  O₂ No

[SHOW IF YES] Please indicate on the scale; how much has having a tremor affected your energy level? (to enter your response below, click on the circle and drag your mouse to the left or right)

<PAGE BREAK>

3. Has this tremor been affecting your ability to do chores around the house?
   O₁ Yes  O₂ No

[SHOW IF YES] Please indicate on the scale; how much has having a tremor affected your ability to do chores around the house? (to enter your response below, click on the circle and drag your mouse to the left or right)

<PAGE BREAK>

4. Has this tremor been affecting your ability to take care of yourself?
   O₁ Yes  O₂ No

[SHOW IF YES] Please indicate on the scale; how much has having a tremor affected your ability to take care of yourself?
5. Has this tremor been affecting how much you avoid or not talk to others?

O1 Yes  O2 No

[SHOW IF YES] Please indicate on the scale; how much has having a tremor affected how much you avoid others?

<PAGE BREAK>

6. Has this tremor been affecting how much you are afraid to go out?

O1 Yes  O2 No

[SHOW IF YES] Please indicate on the scale; how much has having a tremor affected how afraid you are to go out?

<PAGE BREAK>

7. Has this tremor been affecting your ability to get a job or do your job?

O1 Yes  O2 No

[SHOW IF YES] Please indicate on the scale; how much has having a tremor affected your ability to get a job or do your job?

<PAGE BREAK>

8. Has this tremor been affecting your ability to write?

O1 Yes  O2 No
[SHOW IF YES] Please indicate on the scale; Please indicate on the scale; how much has having a tremor affected your ability to write?

<PAGE BREAK>

9. Has this tremor been affecting your ability to grab a glass?
   O1 Yes O2 No

[SHOW IF YES] Please indicate on the scale; Please indicate on the scale; how much has having a tremor affected your ability to grab a glass?

<PAGE BREAK>

10. Has this tremor been affecting any other aspect of your daily functioning?
    O1 Yes O2 No

[SHOW IF YES] Please describe the other aspect(s):

________________________________________________

[SHOW IF YES] Please indicate on the scale; how much has having a tremor affected other aspects of your daily functioning?

<PAGE BREAK>

11. Tremor has an impact on my functioning. □1 True □2 False

<PAGE BREAK>

12. How has your tremor made you feel? (Please check all that apply – if any)
Apathetic/Indifferent
Frustrated
Hopeless
Dissatisfied
Ashamed/Embarrassed
Trusting/Accepting
Overwhelmed
Confused/Doubtful
Impatient/Irritated/Angry
Resigned
None of the above [EXCLUSIVE]

D. FEELING DRUGGED/LIKE A ZOMBIE

[SKIP IF “NEVER” SELECTED FOR ITEM 2 OF GASS]

1. You have said that since taking your current medication that you felt drugged or like a zombie. How long has it been since you experienced feeling drugged or like a zombie?

   O₁ In the past day
   O₂ In the past week
   O₃ In the past month
   O₄ In the past 3 months
   O₅ In the past year

2. Has feeling drugged or like a zombie been affecting your energy level?

   O₁ Yes O₂ No
[SHOW IF YES] Please indicate on the scale; how much has feeling drugged or like a zombie affected your energy level? (to enter your response below, click on the circle and drag your mouse to the left or right)

<PAGE BREAK>

3. Has feeling drugged or like a zombie been affecting your ability to do chores around the house?

  O1 Yes O2 No

[SHOW IF YES] Please indicate on the scale; how much has feeling drugged or like a zombie affected your ability to do chores around the house? (to enter your response below, click on the circle and drag your mouse to the left or right)

<PAGE BREAK>

4. Has this feeling drugged or like a zombie been affecting your ability to take care of yourself?

  O1 Yes O2 No

[SHOW IF YES] Please indicate on the scale; how much has feeling drugged or like a zombie affected your ability to take care of yourself?
5. Has feeling drugged or like a zombie been affecting avoiding or not talking to others?

O1 Yes O2 No

[SHOW IF YES] Please indicate on the scale; how much has feeling drugged or like a zombie affected how much you avoid or not talk to others?

Degree of Impact (0-100)

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6. Has feeling drugged or like a zombie been making you afraid to go out?

O1 Yes O2 No

[SHOW IF YES] Please indicate on the scale; how much has feeling drugged or like a zombie affected how afraid you are to go out?

Degree of Impact (0-100)

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7. Has feeling drugged or like a zombie been affecting your ability to concentrate?

O1 Yes O2 No

[SHOW IF YES] Please indicate on the scale; how much has feeling drugged or like a zombie affected your ability to concentrate?

Degree of Impact (0-100)

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8. Has feeling drugged or like a zombie been affecting your memory?

O1 Yes O2 No
[SHOW IF YES] Please indicate on the scale; how much has feeling drugged or like a zombie affected your **memory**?

![Degree of Impact (0-100)]

**<PAGE BREAK>**

9. Has **feeling drugged or like a zombie** been affecting your **ability to get a job or do your job**?

O1 Yes O2 No

[SHOW IF YES] Please indicate on the scale; how much has feeling drugged or like a zombie affected your **ability to get a job or do your job**?

![Degree of Impact (0-100)]

**<PAGE BREAK>**

10. Has this **feeling drugged or like a zombie** been affecting **any other aspects of your daily functioning**?

O1 Yes O2 No

[SHOW IF YES] Please describe the other aspect(s):

________________________________________________

[SHOW IF YES] Please indicate on the scale; how much has feeling restless and not being able to sit still affected **other aspects of your daily functioning**?

![Degree of Impact (0-100)]

**<PAGE BREAK>**

11. **Feeling drugged or like a zombie** has an impact on my functioning. □1 True □2 False

**<PAGE BREAK>**
12. How does feeling drugged or like a zombie make you feel? (Please check all that apply – if any)

- Apathetic/Indifferent
- Frustrated
- Hopeless
- Dissatisfied
- Ashamed/Embarrassed
- Trusting/Accepting
- Overwhelmed
- Confused/Doubtful
- Impatient/Irritated/Angry
- Resigned
- None of the above [EXCLUSIVE]

E. DIZZINESS

[SKIP IF “NEVER” SELECTED FOR ITEM 3 OF GASS]

1. You have said that since taking your current medication you have felt dizzy when you stood up. How long has it been since you experienced feeling dizzy when you stood up?

- O1 In the past day
- O2 In the past week
- O3 In the past month
- O4 In the past 3 months
- O5 In the past year

2. Has your feeling dizzy been affecting your energy level?
O_1 Yes O_2 No

[SHOW IF YES] Please indicate on the scale; how much has feeling dizzy affected your **energy level**? (*to enter your response below, click on the circle and drag your mouse to the left or right*)

<PAGE BREAK>

3. Has **feeling dizzy** been affecting your **level of physical discomfort**?

O_1 Yes O_2 No

[SHOW IF YES] Please indicate on the scale; how much has feeling dizzy affected your **level of physical discomfort**? (*to enter your response below, click on the circle and drag your mouse to the left or right*)

<PAGE BREAK>

4. Has **feeling dizzy** been affecting your **ability to do chores around the house**?

O_1 Yes O_2 No

[SHOW IF YES] Please indicate on the scale; how much has feeling dizzy affected your **ability to do chores around the house**?
5. Has *feeling dizzy* been affecting your ability to take care of yourself?

O₁ Yes  O₂ No

[SHOW IF YES] Please indicate on the scale; how much has feeling dizzy affected your ability to take care of yourself?

6. Has *feeling dizzy* been affecting *avoiding or not talking to others*?

O₁ Yes  O₂ No

[SHOW IF YES] Please indicate on the scale; how much has feeling dizzy affected how much you avoid or not talk to others?

7. Has *feeling dizzy* been affecting *affected how afraid you are of falling over*?

O₁ Yes  O₂ No

[SHOW IF YES] Please indicate on the scale; how much has feeling dizzy affected how afraid you are of falling over?

8. Has *feeling dizzy* been affecting *your ability to get a job or do your job*?

O₁ Yes  O₂ No
[SHOW IF YES] Please indicate on the scale; how much has feeling dizzy affected your ability to get a job or do your job?

<PAGE BREAK>

9. Has feeling dizzy been making you afraid to going out?

O₁ Yes O₂ No

[SHOW IF YES] Please indicate on the scale; how much has feeling dizzy affected how afraid you are to go out?

O₁ Very little O₂ A little O₃ Moderately O₄ Very Much O₅ Severely

<PAGE BREAK>

10. Has feeling dizzy been affecting any other aspects of your daily functioning?

O₁ Yes O₂ No

[SHOW IF YES] Please describe the other aspect(s):

________________________________________________

[SHOW IF YES] Please indicate on the scale; how much has feeling dizzy affected other aspects of your daily functioning?

<PAGE BREAK>

11. Feeling dizzy has an impact on my functioning. ☐₁ True ☐₂ False

<PAGE BREAK>
12. How has feeling dizzy made you feel? (Please check all that apply – if any)

- Apathetic/Indifferent
- Frustrated
- Hopeless
- Dissatisfied
- Ashamed/Embarrassed
- Trusting/Accepting
- Overwhelmed
- Confused/Doubtful
- Impatient/Irritated/Angry
- Resigned
- None of the above [EXCLUSIVE]

F. DIFFICULTY SLEEPING

[SKIP IF “NEVER” SELECTED FOR ITEM 23 OF GASS]

1. You have said that since taking your current medication that you experienced difficulty sleeping. How long has it been since you experienced difficulty sleeping?

   - O₁ In the past day
   - O₂ In the past week
   - O₃ In the past month
   - O₄ In the past 3 months
   - O₅ In the past year

2. Has difficulty sleeping been affecting your energy level?

   - O₁ Yes O₂ No
[SHOW IF YES] Please indicate on the scale; how much has difficulty sleeping affected your energy level? (to enter your response below, click on the circle and drag your mouse to the left or right)

Degree of Impact (0-100)

<PAGE BREAK>

3. Has difficulty sleeping been affecting your level of physical comfort?
   O1 Yes O2 No

[SHOW IF YES] Please indicate on the scale; how much has difficulty sleeping affected your level of physical discomfort? (to enter your response below, click on the circle and drag your mouse to the left or right)

Degree of Impact (0-100)

<PAGE BREAK>

4. Has difficulty sleeping been affecting your ability to do chores around the house?
   O1 Yes O2 No

[SHOW IF YES] Please indicate on the scale; how much has difficulty sleeping affected your ability to do chores around the house?
5. Has difficulty sleeping been affecting your ability to take care of yourself?
   - O1 Yes  O2 No

[SHOW IF YES] Please indicate on the scale; how much has difficulty sleeping affected your ability to take care of yourself?

<PAGE BREAK>

6. Has difficulty sleeping been affecting your avoiding or not talking to others?
   - O1 Yes  O2 No

[SHOW IF YES] Please indicate on the scale; how much has difficulty sleeping affected how much you avoid others?

<PAGE BREAK>

7. Has difficulty sleeping been making you afraid of going out?
   - O1 Yes  O2 No

[SHOW IF YES] Please indicate on the scale; how much has difficulty sleeping affected how afraid you are to go out?

<PAGE BREAK>

8. Has difficulty sleeping been affecting your ability to get a job or do your job?
   - O1 Yes  O2 No
Please indicate on the scale; how much has difficulty sleeping affected your ability to get a job or do your job?

<PAGE BREAK>

9. Has difficulty sleeping been affecting your ability to concentrate?

O1 Yes O2 No

Please indicate on the scale; how much has difficulty sleeping affected your ability to concentrate?

<PAGE BREAK>

10. Has difficulty sleeping been affecting your ability to follow classes?

O1 Yes O2 No

Please indicate on the scale; how much has difficulty sleeping affected your ability to follow classes?

<PAGE BREAK>

11. Has difficulty sleeping been affecting your ability to drive?

O1 Yes O2 No

Please indicate on the scale; how much has difficulty sleeping affected your ability to drive?
12. Has difficulty sleeping been affecting any other aspects of your daily functioning?

O₁ Yes O₂ No

[SHOW IF YES] Please describe the other aspect(s):

_________________________________________________________________________________

[SHOW IF YES] Please indicate on the scale; how much has difficulty sleeping affected other aspects of your daily functioning?

<PAGE BREAK>

13. Difficulty sleeping has an impact on my functioning. □₁ True □₂ False

<PAGE BREAK>

14. How has your difficulty sleeping made you feel? (Please check all that apply – if any)

Apathetic/Indifferent
Frustrated
Hopeless
Dissatisfied
Ashamed/Embarrassed
Trusting/Accepting
Overwhelmed
Confused/Doubtful
Impatient/Irritated/Angry
Resigned
None of the above [EXCLUSIVE]

G. PROBLEMS ENJOYING SEX

[IF FEMALE: SKIP IF “NEVER” SELECTED FOR ITEM 19 OF GASS; IF MALE: SKIP IF “NEVER” SELECTED FOR BOTH ITEMS 19 & 20 OF GASS]

1. You have said that since taking your current medication you have had problems enjoying sex. How long has it been since you experienced **problems enjoying sex**?

   O1 In the past day  
   O2 In the past week  
   O3 In the past month  
   O4 In the past 3 months  
   O5 In the past year

<PAGE BREAK>

2. **Have problems enjoying sex** been affecting your physical discomfort?

   O1 Yes O2 No

[SHOW IF YES] Please indicate on the scale; how much has problems enjoying sex affected your physical discomfort? *(to enter your response below, click on the circle and drag your mouse to the left or right)*

<PAGE BREAK>

3. **Have problems enjoying sex** been affecting your ability to communicate with your partner?

   O1 Yes O2 No
[SHOW IF YES] Please indicate on the scale; how much has problems enjoying sex affected how much your ability to communicate with your partner? (to enter your response below, click on the circle and drag your mouse to the left or right)

4. Have problems enjoying sex been affecting your intimate relationships?
   O1 Yes O2 No

[SHOW IF YES] Please indicate on the scale; how much has problems enjoying sex affected your intimate relationships?

5. Have problems enjoying sex been affecting any other aspects of your daily functioning?
   O1 Yes O2 No

[SHOW IF YES] Please describe the other aspect(s):

__________________________________________________________

[SHOW IF YES] Please indicate on the scale; how much have problems having sex affected other aspects of your daily functioning?

6. Problems enjoying sex has an impact on my functioning. □ 1 True □ 2 False

<PAGE BREAK>
7. How have your problems enjoying sex made you feel? (Please check all that apply – if any)

Apathetic/Indifferent
Frustrated
Hopeless
Dissatisfied
Ashamed/Embarrassed
Trusting/Accepting
Overwhelmed
Confused/Doubtful
Impatient/Irritated/Angry
Resigned
Self-conscious
Worthless
Feel a lack of love
None of the above [EXCLUSIVE]

<H. WEIGHT GAIN>

[SKIP IF “NEVER” SELECTED FOR ITEM 22 OF GASS]

1. You have said that since taking your current medication you have had problems with weight gain. How long has it been since you experienced weight gain?

   O₁ In the past day
   O₂ In the past week
   O₃ In the past month
   O₄ In the past 3 months
In the past year

2. Has your weight gain been affecting your energy level?
   O₁ Yes  O₂ No

   [SHOW IF YES] Please indicate on the scale; how much has weight gain affected your energy level? (to enter your response below, click on the circle and drag your mouse to the left or right)

   Degree of Impact (0-100)

3. Has your weight gain affected your ability to put on or take off clothing?
   O₁ Yes  O₂ No

   [SHOW IF YES] Please indicate on the scale; how much has weight gain affected your ability to put on or take off clothing? (to enter your response below, click on the circle and drag your mouse to the left or right)

   Degree of Impact (0-100)

4. Has your weight gain affected your ability to do chores around the house?
   O₁ Yes  O₂ No

   [SHOW IF YES] Please indicate on the scale; how much has weight gain affected your ability to do chores around the house?
5. Has your weight gain affected your ability to take care of yourself?

- Yes
- No

[SHOW IF YES] Please indicate on the scale; how much has weight gain affected your ability to take care of yourself?

6. Has your weight gain affected your fear of being rejected?

- Yes
- No

[SHOW IF YES] Please indicate on the scale; how much has weight gain affected your fear of being rejected?

7. Has your weight gain affected how afraid you are to go out?

- Yes
- No

[SHOW IF YES] Please indicate on the scale; how much has weight gain affected how afraid you are to go out?

8. Has your weight gain caused you to experience ridicule, teasing, or unwanted attention?

- Yes
- No
[SHOW IF YES] Please indicate on the scale; how much has weight gain caused you to experience ridicule, teasing, or unwanted attention?

<PAGE BREAK>

9. Has your weight gain affected your ability to meet responsibilities or given you difficulty in getting things done?

O₁ Yes O₂ No

[SHOW IF YES] Please indicate on the scale; how much has weight gain affected your ability to meet responsibilities or given you difficulty in getting things done?

<PAGE BREAK>

10. Has your weight gain affected your ability to have an intimate relationship?

O₁ Yes O₂ No

[SHOW IF YES] Please indicate on the scale; how much has weight gain affected your ability to have an intimate relationship?

<PAGE BREAK>

11. Has your weight gain been affecting any other aspects of your daily functioning?

O₁ Yes O₂ No

[SHOW IF YES] Please describe the other aspect(s):

__________________________________________________________________________________________
[SHOW IF YES] Please indicate on the scale; how much has weight gain affected other aspects of your daily functioning?

12. Weight gain has an impact on my functioning. □₁ True □₂ False

13. How has your weight gain made you feel? (Please check all that apply – if any)

- Lack of confidence
- Feel Worthless
- Apathetic/Indifferent
- Frustrated
- Hopeless
- Dissatisfied
- Ashamed/Embarrassed
- Trusting/Accepting
- Overwhelmed
- Confused/Doubtful
- Impatient/Irritated/Angry
- Resigned
- I was trying to gain weight, so it was not an issue for me

None of the above [EXCLUSIVE]