**Supplementary Material 1**

**Short Multidimensional Inventory Lifestyle Evaluation (SMILE)**

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| --- | --- | --- | --- | --- | --- |
| ***Domain*** | ***In the last month, how often in your daily routine…*** | ***Always*** | ***Often*** | ***Seldom*** | ***Never*** |
| **Diet and Nutrition** | 1. Do you eat meals you or someone else in your family prepares?
 | 4 | 3 | 2 | 1 |
| 1. When shopping for food, do you check labels for ingredients such as quantity of salt?
 | 4 | 3 | 2 | 1 |
| 1. Do you eat processed food (frozen food such as pizza, French fries, puff pastries, deep-fried foods and canned foods)?
 | 1 | 2 | 3 | 4 |
| 1. Do you eat fast-food, high-calorie sweet or fatty foods when you are stressed or sad?
 | 1 | 2 | 3 | 4 |
| 1. Do you eat healthy foods such as fresh fruits, fresh vegetables, wholegrain, legumes or nuts?
 | 4 | 3 | 2 | 1 |
| 1. Do you keep a regular meal schedule?
 | 4 | 3 | 2 | 1 |
| 1. Do you share your main meals with friends or family?
 | 4 | 3 | 2 | 1 |
| **Substance Use** | 1. Do you drink 5 or more doses (men) or 4 or more doses (women) of alcoholic beverages on a single occasion, which means within 2 hours? (1 dose of alcohol=1 glass of beer OR 1 glass of wine OR 1 shot of spirit (such as rum, vodka, whisky, tequila or gin)).
 | 1 | 2 | 3 | 4 |
| 1. Do you smoke tobacco (cigarette, electronic cigarette, cigar, pipe, smokeless tobacco)?
 | 1 | 2 | 3 | 4 |
| 1. Do you use marijuana or hashish?
 | 1 | 2 | 3 | 4 |
| 1. Do you use other drugs (cocaine, crack, amphetamines, ecstasy, opioids without medical prescription, and others)?
 | 1 | 2 | 3 | 4 |
| **Physical activity** | 1. Do you exercise for at least 30 minutes daily (or 150 minutes a week)?
 | 4 | 3 | 2 | 1 |
| 1. Do you play at least 2 hours of team sports (like soccer, volleyball, basketball, rugby, etc.) a week?
 | 4 | 3 | 2 | 1 |
| 1. Do you choose to climb stairs instead of using an elevator and/or walking to perform your daily routines instead of using a car/public transportation?
 | 4 | 3 | 2 | 1 |
| 1. Do you feel good after performing physical activity?
 | 4 | 3 | 2 | 1 |
| **Stress management** | 1. Do you make time to relax?
 | 4 | 3 | 2 | 1 |
| 1. Do you use any strategy or psychological support to deal with stress (for instance meditation, mindfulness or psychotherapy)?
 | 4 | 3 | 2 | 1 |
| 1. Do you use physical strategies to deal with stress (for instance yoga, tai-chi, exercise)?
 | 4 | 3 | 2 | 1 |
| 1. Do you practice a faith or religion?
 | 4 | 3 | 2 | 1 |
| 1. Do you feel that you have a good work-life balance?
 | 4 | 3 | 2 | 1 |
| 1. Do you feel that your work / chores are never done?
 | 1 | 2 | 3 | 4 |
| 1. Are you satisfied with the time it takes you to commute to work?
 | 4 | 3 | 2 | 1 |
| 1. Do you feel that your life has a meaning?
 | 4 | 3 | 2 | 1 |
| 1. Do you feel grateful for the life you have?
 | 4 | 3 | 2 | 1 |
| **Restorative sleep** | 1. Do you manage to sleep between 7 and 9 hours per night?
 | 4 | 3 | 2 | 1 |
| 1. Do you feel rested with the number of hours you sleep?
 | 4 | 3 | 2 | 1 |
| 1. Do you usually rest (sleep or take a nap) after lunch?
 | 4 | 3 | 2 | 1 |
| 1. Do you maintain a regular sleep schedule?
 | 4 | 3 | 2 | 1 |
| 1. Do you use sleeping pills?
 | 1 | 2 | 3 | 4 |
| **Social support** | 1. Do you interact with your friends and/or relatives?
 | 4 | 3 | 2 | 1 |
| 1. Do you feel that you are part of a group of friends, the community or the society?
 | 4 | 3 | 2 | 1 |
| 1. Do you have someone you trust who listens to your problems or concerns?
 | 4 | 3 | 2 | 1 |
| 1. Do you have someone to help with everyday chores (for instance cooking, housekeeping, shopping)?
 | 4 | 3 | 2 | 1 |
| 1. Do you have someone in your life to go out or have fun with when you fell like it?
 | 4 | 3 | 2 | 1 |
| 1. Do you take part in celebrations/ reunions with family/ friends/colleagues?
 | 4 | 3 | 2 | 1 |
| 1. Do you enjoy your leisure time?
 | 4 | 3 | 2 | 1 |
| 1. Do you make yourself available to support your significant ones?
 | 4 | 3 | 2 | 1 |
| 1. Are you satisfied with your sexual life?
 | 4 | 3 | 2 | 1 |
| 1. Do you feel loved?
 | 4 | 3 | 2 | 1 |
| **Environment exposures (screen time/ outdoor time)** | 1. Do you spend more than 2 hours a day watching TV, playing computer games, video games or in the internet:
 | 1 | 2 | 3 | 4 |
| 1. Do you spend time on a computer / smartphone within one hour of going to sleep?
 | 1 | 2 | 3 | 4 |
| 1. Are you in touch with nature (for instance parks, beach, countryside, mountains)?
 | 4 | 3 | 2 | 1 |
| 1. Do you feel your relationship to nature, that is all living things, is an important part of who you are?
 | 4 | 3 | 2 | 1 |