**Supplementary material 2**

**Short Multidimensional Inventory Lifestyle Evaluation -CONFINEMENT (SMILE-C)**

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| --- | --- | --- | --- | --- |
| ***In the last month, how often in your daily routine…*** | ***Always*** | ***Often*** | ***Seldom*** | ***Never*** |
| 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 |
| 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 |
| 1. Do you exercise for at least 30 minutes daily (or 150 minutes a week)?
 | 4 | 3 | 2 | 1 |
| 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 your life has a meaning?
 | 4 | 3 | 2 | 1 |
| 1. Do you feel grateful for the life you have?
 | 4 | 3 | 2 | 1 |
| 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 maintain a regular sleep schedule?
 | 4 | 3 | 2 | 1 |
| 1. Do you use sleeping pills?
 | 1 | 2 | 3 | 4 |
| 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 enjoy your leisure time?
 | 4 | 3 | 2 | 1 |
| 1. Do you make yourself available to support your significant ones?
 | 4 | 3 | 2 | 1 |
| 1. Do you spend time on a computer / smartphone within one hour of going to sleep?
 | 1 | 2 | 3 | 4 |