

**CAFFEINE CONSUMPTION QUESTIONNAIRE (CCQ)**

Please answer the following questions as completely and honestly as you can. This information is **STRICTLY CONFIDENTIAL** – do not write your name anywhere on this page. Thank you for your cooperation.

Please answering the following questions about your caffeine usage. Respond to items that you consume at least once a week.

COFFEE (5 oz servings/week)	MORNING 6am-12nn	AFTERNOON 12nn-6pm	EVENING 6pm-2am	NIGHT 2am-6am
Regular brewed	_____	_____	_____	_____
Percolated	_____	_____	_____	_____
Drip-brewed	_____	_____	_____	_____
Regular instant	_____	_____	_____	_____
Decaffeinated	_____	_____	_____	_____
Brewed	_____	_____	_____	_____
Instant	_____	_____	_____	_____
TEA (5 oz serv/week)				
COCOA (5 oz serv/week)				
CHOCOLATE (8 oz serv/week)				
SOFT DRINKS (12 Oz. Serv/Week)	MORNING 6am-12nn	AFTERNOON 12nn-6pm	EVENING 6pm-2am	NIGHT 2am-6am
Coca-Cola	_____	_____	_____	_____
Diet Coca-Cola	_____	_____	_____	_____
Dr. Pepper	_____	_____	_____	_____
Diet Dr. Pepper	_____	_____	_____	_____
Mountain Dew	_____	_____	_____	_____
Diet Mountain Dew	_____	_____	_____	_____
Mr. Pibb	_____	_____	_____	_____
Diet Mr. Pibb	_____	_____	_____	_____
Tab	_____	_____	_____	_____
Pepsi Cola	_____	_____	_____	_____
Diet Pepsi Cola	_____	_____	_____	_____
RC Cola	_____	_____	_____	_____
Mello Yello	_____	_____	_____	_____
Diet Mello Yello	_____	_____	_____	_____
Root Beer	_____	_____	_____	_____
Red Bull	_____	_____	_____	_____
OVER-THE-COUNTER DRUGS (Tablets/week)				
Vivarin	_____	_____	_____	_____
NoDoz	_____	_____	_____	_____
Excedrin	_____	_____	_____	_____
Vanquish	_____	_____	_____	_____
Anacin	_____	_____	_____	_____
Dristan	_____	_____	_____	_____
Dexatrim	_____	_____	_____	_____