





Health questionnaire for children and young people aged 11-18 to answer directly.

These questions are to be answered by the Young Person who had the Covid-19 test.

If you need any help, please ask a parent, relative, carer or friend to help you.

For questions that ask for a particular date, don't worry if you can't remember it exactly, just enter the closest date.

The questions **do not** need to be completed in one go but can be paused and continued at a later time – just remember to click save.

All of the information which you provide will be kept confidential and will not be shared with anyone outside the research team studying Long Covid in young people.



About you
How tall are you?(□ cm □ metres □ feet/inches) □ Not sure
What is your weight now?(□ kg □ stone □ lbs) □ Not sure
About your Covid-19 test
Have you had a COVID-19 test since the last time you completed this questionnaire? $ Yes \; \Box \; No$
How many COVID-19 tests have you had?
When was your COVID-19 test? (if more than 1: please enter date of your first COVID-19 test)
If more than 1: When was your most recent COVID-19 test?
What was the result? (please answer in relation to your last COVID-19 test) □ Positive □ Negative
Is this your first positive result?
□ Yes □ No
Even though your test was negative, do you believe that you had COVID-19? (please answer these in relation to your last Covid-19 test) Yes No Not sure
What was the reason for your most recent Covid-19 test? (please answer these in relation to your last COVID-19 test) I had some symptoms. I was near someone who had tested positive School testing Other
If had symptoms, following questions will appear the first time the questionnaire is given. When did you first notice them? (please answer these in relation to your last COVID-19 test)





	OF CHILD HEALTH England long did they last? (please answer these in relation to your last COVID-19 test)
	□ A day or less □ a few days □ about a week □ more than a week □ A couple of weeks or more
How test)	bad were the symptoms at their worst? (please answer these in relation to your last COVID-19
	□ Not very – I could carry on doing things □ a little – I felt a little bit poorly □ quite bad – I had to go to bed sometimes □ very bad – I couldn't do much □ Extremely bad – I couldn't do anything
	e last four weeks, how many school days (online or in person) in total did you miss because of otoms of COVID-19
	None □ 1-2 days □ 3-5 days □ 6-10 days □ 11-15 days □ More than 15 days
	t symptoms did you have? (Check all that apply) (please answer these in relation to your last ID-19 test).
	chills or shivers (feeling too cold) persistent cough (coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours) unusual fatigue/tiredness unusual shortness of breath oss of smell/taste unusually hoarse voice unusual chest pain or tightness in your chest unusual abdominal pain diarrhoea headache confusion, disorientation or drowsiness unusual eye-soreness or discomfort (e.g. light sensitivity, excessive tears, or pink/red eye) skipping meals dizziness or light-headedness sore throat unusual strong muscle pains earache or ringing in your ears (tinnitus) raised, red, itchy welts on the skin or sudden swelling of the face or lips red/purple sores or blisters on your feet, including your toes other
If oth	er, please state
Wha	t were your <i>main</i> symptoms? (please answer these in relation to your last COVID-19 test)
	Fever

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REAT C	Public Health England persistent cough (coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours) unusual fatigue/tiredness unusual shortness of breath loss of smell/taste unusually hoarse voice unusual chest pain or tightness in your chest unusual abdominal pain diarrhoea headache confusion, disorientation or drowsiness unusual eye-soreness or discomfort (e.g. light sensitivity, excessive tears, or pink/red eye) skipping meals dizziness or light-headedness sore throat unusual strong muscle pains
	earache or ringing in your ears (tinnitus) raised, red, itchy welts on the skin or sudden swelling of the face or lips red/purple sores or blisters on your feet, including your toes other
	w severe would you rate your symptoms? 0 (not severe at all) to 100 (extremely severe)
	0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90

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GREAT ORMOND STREET
INSTITUTE OF CHILD HEALTH

Public Health
England

REAT ORMOND STREET STITUTE OF CHILD HEALTH England How much do your symptoms affect your functioning? 0 (not at all) to 100 (extremely)
0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
Did you/your parent talk to the doctor about your Covid-19 symptoms? (please answer these in relation to your last COVID-19 test) ☐ Yes ☐ No
Did you go to hospital about your Covid-19? (please answer these in relation to your last COVID-19 test) □ Yes □ No
Did you have to stay overnight in hospital for Covid-19? (please answer these in relation to your last COVID-19 test) Yes □ No
Have you had a vaccination against COVID-19?
□ Yes □ No
The questions below will be asked if they answer 'Yes' to the above.
How many vaccines have you had? □ 1 □ 2 □ 3 □ Unsure
Which vaccine did you have? (if more than 1: please answer in relation to your first vaccine)

PARTICIPANT IDENTIFICATION #: [__][__][__]-[__][__][__]





□ Pfizer □ AstraZeneca □ Moderna □ Unsure					
When did you have the vaccine? (if more than 1: please answer in relation to your first vaccine)					
If they report two vaccines the below will also be asked.					
What was the second vaccine?					
□ Pfizer □ AstraZeneca □ Moderna □ Unsure					
When did you have the second vaccine?					
If they report three vaccines the below will also be asked.					
What was the third vaccine?					
□ Pfizer □ AstraZeneca □ Moderna □ Unsure					
When did you have the third vaccine?					
About your health at the moment					
If you have had symptoms of COVID-19, how much do you agree with the following statement?					
"I have fully recovered from COVID-19"					
□ 0 - Strongly Disagree					
□ 2 □ 3					
\Box 4					
□ 5 - Neutral					
□ 6					
□ 7					
9 9 10 Strongly Agree					
☐ 10 - Strongly Agree					

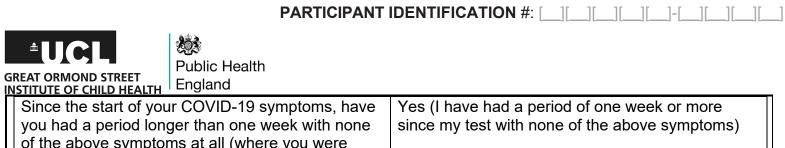
PARTICIPANT IDENTIFICATION #: [__][__][__]-[__][__][__]







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How do you feel right now?	I feel as healthy as normal
	I am not feeling quite right
Do you have a fever?	Yes/No
Do you feel chills or shivers (feel too cold)?	Yes/No
If you are able to measure it, what is your temperature?	
Do you have a persistent cough (coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours)?	Yes/No
Are you experiencing unusual fatigue/tiredness?	No
	Mild fatigue Severe fatigue - I struggle to get out of bed
Are you experiencing problems with your sleep, including getting to sleep, waking in the night or waking early?	Yes/No
If yes, please describe	
Are you experiencing unusual shortness of breath?	No
	Yes, mild symptoms - slight shortness of breath during ordinary activity Yes, significant symptoms - breathing is comfortable only at rest Yes, severe symptoms - breathing is difficult even at rest
What are your current symptoms? (Please tick all that apple loss of smell/taste unusually hoarse voice unusual chest pain or tightness in your chest unusual abdominal pain diarrhoea headache confusion, disorientation or drowsiness unusual eye-soreness or discomfort (e.g. light sensitive skipping meals dizziness or light-headedness sore throat unusual strong muscle pains earache or ringing in your ears (tinnitus) raised, red, itchy welts on the skin or sudden swellin red/purple sores or blisters on your feet, including your no symptoms other	tivity, excessive tears, or pink/red eye) ng of the face or lips our toes



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	Since the start of your COVID-19 symptoms, have	Yes (I have had a period of one week or more
	you had a period longer than one week with none	since my test with none of the above symptoms)
	of the above symptoms at all (where you were	
	back to how you were pre-COVID)	No (My symptoms have been continuous since
		Covid test)
		,
		Not applicable
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Public Health	
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How v	vou :	feel	about	vour	overall	health
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Describing your health TODAY

Under each heading, please tick the ONE box that describes your health TODAY

Mobility (walking about)

I have <u>no</u> problems walking about			
I have <u>some</u> problems walking about			
I have <u>a lot</u> of problems walking about			

Looking after myself

I have <u>no</u> problems washing or dressing myself	
I have some problems washing or dressing myself	
I have a lot of problems washing or dressing myself	

Doing usual activities (for example, going to school, hobbies, sports, playing, doing things with family or friends)

PARTICIPANT IDENTIFICATION #: [__][__][__]-[__][__]

I have <u>no</u> problems doing my usual activities	
I have some problems doing my usual activities	
I have <u>a lot of</u> problems doing my usual activities	

Having pain or discomfort

I have <u>no</u> pain or discomfort	
I have <u>some</u> pain or discomfort	
I have <u>a lot of</u> pain or discomfort	

Feeling worried, sad or unhappy

reening worned, sad or dimappy	
I am <u>not</u> worried, sad or unhappy	
I am <u>a bit</u> worried, sad or unhappy	
I am very worried, sad or unhappy	

TODAY

Questions	Hardly Ever or Never	Some of the time	Often
1. How often do you feel that you have no one to talk to?	1	2	3
2. How often do you feel left out?	1	2	3
3. How often do you feel alone?	1	2	3

	Often/Always	Some of the time	Occasionally	Hardly Ever	Never
4. How often do you feel lonely?	1	2	3	4	5

We would like to know how good or bad your health is **TODAY**

This scale is numbered from 0 to 100%

100% means the best health you can think of

0% means the worst health you can think of.

Please look at the scale and select the number for your health TODAY

Today

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	25			
	30			
	35			
	40			
	45			
	50			
	55			
	60			
	65			
	70			
	75			
	80			
	85			
	90			

Covid-19 and your family

□ 95□ 100

Has Covid-19 affected your family members and if so, can you tell us who? (Kelsey – skip rule if say 'no')

who? (Keisey – Skip i	uie II	Say	110)					
	In your house			In your extended family (Grandparents, aunts, uncles etc)				
	Yes	No	Don't know	Who?	Yes	No	Don't know	Who?
Has anyone tested positive for Covid-19?								
Has anyone been to hospital with Covid-19?								
Has anyone been in intensive care (ICU) with Covid-19?								
Has anyone died from Covid-19?								
Does anyone have ongoing problems from Covid-19?								





PARTICIPANT IDENTIFICATION #: [__][__][__]-[__][__][__][

Wellbeing

Strengths and difficulties questionnaire

For the next set of questions, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the question seems daft! Please give your answers on the basis of how things have been for you over the PAST
MONTH.

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings			
I am restless, I cannot stay still for long			
I get a lot of headaches, stomach-aches, or sickness			
I usually share with others (food, games, pens etc.)			
I get very angry and often lose my temper			
I am usually on my own. I generally play alone or keep to myself			
I usually do as I am told			
I worry a lot			
I am helpful if someone is hurt, upset, or feeling ill			
I am constantly fidgeting or squirming			
I have one good friend or more			
I fight a lot. I can make other people do what I want			
I am often unhappy, down-hearted or tearful			
Other people my age generally like me			
I am easily distracted, I find it difficult to concentrate			
I am nervous in new situations. I easily lose confidence			
I am kind to younger children			
I am often accused of lying or cheating			
Other children or young people pick on me or bully me			
I often volunteer to help others (parents, teachers, children)			
I think before I do things			
I take things that are not mine from home, school or elsewhere			
I get on better with adults than with people my own age			
I have many fears, I am easily scared			
I finish the work I'm doing. My attention is good			

Overall, do you think that you have difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes –	Yes –	Yes –
	minor	definite	severe
	difficulties	difficulties	difficulties

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year

• Do the difficulties upset or distress you?

Not at all	Only a little	Quite a lot	A great deal	

• Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE				
FRIENDSHIPS				
CLASSROOM LEARNING				
LEISURE ACTIVITIES				

• Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Not at		Quite a	
all	little	lot	deal





Chalder Fatigue Scale

We would like to know more about any problems you have had with feeling tired, weak or lacking in energy in the **LAST MONTH**. Please answer ALL the questions by ticking the answer which applies to you most closely. If you have been feeling tired for a long while, then compare yourself to how you felt when you were last well.

PARTICIPANT IDENTIFICATION #: [__][__][__]-[__][__][__]

	less than usual	no more than usual	more than usual	much more than usual
do you have problems with tiredness?				
do you need to rest more?				
do you feel sleepy or drowsy?				
do you have problems starting things?				
do you lack energy?				
do you have less strength in your muscles?				
do you feel weak?				
do you have difficulties concentrating?				
do you make slips of the tongue when speaking?				
do you find it more difficult to find the right word?				
	better than usual	no worse than usual	worse than usual	much worse than usual
how is your memory?				

Please tick the box that best describes your experience of each over the last 2 weeks.

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

FINAL QUESTION

Please use this space if there is there anything else you would like to tell u your health or how the pandemic or lockdown have affected you.							

PARTICIPANT IDENTIFICATION #: [__][__][__]-[__][__][__]

This research study cannot offer treatment. If you feel you would like some help, please contact

- your GP
- ChildLine www.childline.org.uk
- NHS 111 111.nhs.uk/, or call on 111
- Shout giveusashout.org/, or text 85258

Thank you

Thank you so much for completing this questionnaire.

We will send you the same questionnaire again at a later time.

You will be asked to complete the questionnaire a total of two or three times.

After completing each questionnaire, you will receive a £10 voucher.

Please remember to click submit