Information Sheet & Consent Form

INFORMATION SHEET

Study Title: **Online Survey on Recovery from COVID-19**

Principal Investigator: **Dr. Athena Akrami, PhD; Sainsbury Wellcome Centre, UCL (email: athena.akrami@ucl.ac.uk)**

Project Ethics ID: **16159/002**

Study Investigators:

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Invitation to Participate

You are being invited to participate in this research study because you previously experienced or you are currently experiencing symptoms consistent with COVID-19 as a result of suspected or confirmed SARS-CoV-2 infection.

1. Why is this study being done?

The aim of this research study is to better describe and understand the patient experience and recovery of those with confirmed or suspected COVID-19, with a specific emphasis on the Long COVID experience. The focus of this study includes participants' backgrounds, testing, symptoms,

and psychological wellbeing. A secondary aim of this study is to publish patient-driven data in order to advocate for the Long COVID population within the medical community. The survey was created by a group of patients with COVID-19 symptoms who are members of the **Body Politic online COVID-19 support group**.

2. How long will you be in the study?

This survey will be live for at least **2** weeks, but no more than **4** weeks. As new information about COVID-19 infections is discovered, the team may decide to continue their investigation with follow-up surveys (up to 4 more surveys). The data that you enter in this survey may be linked to data you enter in future surveys.

3. What are the study procedures?

If you agree to participate after reading this message, you will be taken to the survey which is housed on the Qualtrics platform. You will be asked to answer the questions to the best of your ability. In the mental health section and any question marked as optional, you can choose whether or not you would like to respond. The information that you enter will be collected after each page. You can take breaks and return to finish the survey at any time within one week.

4. What type of questions will be asked?

The survey asks different questions on testing, diagnosis, symptoms, treatments, background information, coping methods, as well as health and mental health.

5. Who can fill the survey? (inclusion/exclusion criteria)

You are being invited to participate in this research study because you have had a COVID-19, or suspected COVID-19 infection (still suffering or suffered symptoms) for longer than 1 week, and you are 18 years of age or older.
Even if your COVID-19 test result was negative, or you were not tested at all, please participate in the survey.

6. How long it will take to fill the survey?

The survey can take between sessions 45-75 minutes to complete. You can take breaks and return to finish the survey at any time within one week.

7. Are there any risks to participating in this study?

There are no known risks associated with this research study. In order to mitigate risks inherent in all online surveys, this survey will be conducted on the Qualtrics platform.

8. What are the benefits for participating in this study?

There are no known direct benefits associated with participating in this research study. Your experiences will help us to better define the recovery from the COVID19 and improve advocacy for Long COVID (long-hauler) population.

9. Can participants choose to leave the study?

Participation in this study is voluntary. You may refuse to participate or at any point during the survey, if you decide to opt out from our study, you can fill this form by providing the anonymous ID we generate for you. Once you submit the survey you will be unable to withdraw your data.

10. How will participants' information be kept confidential?

There will be no information collected that may in any way identify you based upon your responses.
Email addresses will only be used to send you a link to the survey, or to notify you of future surveys. A cryptographic algorithm will be used to generate a hash code from each email address. Hash codes will link survey responses to a unique participant without revealing the participant's email address or identity. Paired email addresses and hash codes will be stored in a GDPR-compliant email database managed by a secure hosting provider. Survey responses will be stored on a separate server in a secure, encrypted format. Email addresses will not be stored with survey responses and will remain

unknown to both the research team and the hosting company. **Any data exported will only be used by the above survey investigators, and exported data will be housed solely on secure servers.**
Your responses will be housed on a secure server for **10 years**, after which they will be destroyed. Anonymized data may be made public or shared with any other researchers.

11. Are participants paid to be in this study?

You will receive no monetary compensation or gifts for participating in this study.

12. Conflict of Interest

The questions in this survey were created by the investigators listed above. All investigators have no conflicts of interests to disclose.

13. Whom do participants contact for questions?

If you have any questions about the study, please contact **Athena Akrami**. Please note that email is not a secure form of communication. Please contact UCL ethics committee in case of complaint (ethics@ucl.ac.uk, the UCL Data Protection Officer, Alexandra Potts, a.potts@ucl.ac.uk)

14. Local Data Protection Privacy Notice

Notice: The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice: For participants in health and care research studies, click here (https://www.ucl.ac.uk/legal-services/privacy/ucl-general-privacy-notice-participants-and-researchers-health-and-care-research-studies). The information that is required to be provided to

participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.
The lawful basis that will be used to process your personal data are: 'Public task' for personal data and' Research purposes' for special category data.
Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible. If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

If you have any questions or concerns about the study, or about your rights as a research participant or the conduct of this study, you may contact **Athena Akrami**. If you feel your concerns have not been handled satisfactorily, you can contact the Chair of the UCL Research Ethics Committee at ethics@ucl.ac.uk. This office oversees the ethical conduct of research studies and is not part of the study team. Everything that you discuss will be kept confidential.
Download Here

CONSENT FORM

This study has been approved by the UCL Research Ethics Committee: Project ID number: 16159/002

Thank you for considering taking part in this research.

This survey is voluntary. You may decline to answer any of the questions. By checking the box below you are acknowledging that you are voluntarily participating in this survey, have read and understood the Information Sheet, and consent to the following:

- I understand that my participation is voluntary and that I am free to withdraw at

any time without giving a reason.

- I understand I will need to provide an email address so that I can be sent the future surveys to answer. However, this email address will not be passed to any third parties and will be removed from my answers before any analysis takes place, so the information I provide will be anonymised.
- I understand that due to this anonymisation it will not be possible to withdraw my answers after they have been submitted, but I can withdraw from future surveys at any point.
- I understand that the data gathered in this study will be stored securely and it will not be possible to identify me in any outputs from this research.
- I understand that the data will not be made available to any commercial organisations but is solely the responsibility of the researcher(s) undertaking this study.
- I understand the direct/indirect benefits of participating.
- I understand that I will not benefit financially from this study or from any possible outcome it may result in in the future.
- I agree that my anonymized research data may be used by others for future research. No one will be able to identify me when this data is shared.
- I understand that the information I have submitted will be published as a report.
- I hereby confirm that I understand the inclusion criteria as detailed in the Information Sheet
- I understand the exclusion criteria as detailed in the Information Sheet
- I do not fall under the exclusion criteria.
- I am aware of who I should contact if I wish to log a complaint.
- I voluntarily agree to take part in this study.
- I would be happy for the data I provide to be securely archived at UCL until project completion
- I understand that other authenticated researchers working on this study at UCL will have access to my anonymized data

○ I consent

○ I do not consent

Please enter your email address. We will generate an anonymous ID and redirect you to the survey. Your responses cannot be linked to your email address. At any point during the survey, if you decide to opt out from our study, you can fill this form and provide the anonymous ID.

Your email address will be saved on a **GDPR-compliant email database** managed by a secure hosting provider.

We may send you occasional emails about this current survey, our research results and future surveys.

- ○ Sure
- ○ No, don't send me emails

[No Consent] Thank you page

You have not provided consent to the terms of this study, therefore you cannot participate in our study.

If you would like to participate, please press the back bottom, read the Information Sheet and click the "I consent" button.

For more information, please visit our Patient-Led Research Group for COVID-19

Powered by Qualtrics

Information needed

You may find it helpful to have the below items ready as you complete the survey. *If you do not have these items, please still fill in the information as best you can.*

Testing results	*Dates, type (PCR, antibody) and result of tests If you do not remember the exact date, the estimated date is enough. If you have had antibody tests, we will ask about the manufacturer, but this information is not required.*
Symptom time and severity	*Your symptom log You will be asked to pick symptoms you had **during the first 4 weeks**, and the subsequent months after that, **up to month 7**.*
Other diagnostic tests	*Your medical test results You will be asked several questions about medical testing for your COVID-19 physical symptoms (blood tests, MRI/CT scans/X-rays, ultrasounds, ECGs). If you don't have these tests, that is fine.*

Take a Break

Please remember that at any point, you may stop and resume this survey at a later time. We recommend taking breaks especially if you are currently experiencing

symptoms in order to limit mental exertion.

To return to the survey:

- **Save the link that is in your browser to continue with the survey later.**
- Do not complete the survey in private/incognito mode.
- Do not clear your browser cookies.

Your progress will be saved for **one week**.

Demographics

In which country do you currently reside? *

What city do you live in? Please include state if applicable. (i.e. New York, NY) *

What type of area do you live in? *

- ◯ Suburban
- ◯ Urban
- ◯ Rural

What age group do you fall into? *

- ◯ 18-29
- ◯ 30-39
- ◯ 40-49
- ◯ 50-59
- ◯ 60-69
- ◯ 70-79
- ◯ 80+

What is your gender? *

- ◯ Female/Woman
- ◯ Male/Man
- ◯ Non-binary/Genderqueer/Gender non-conforming
- ◯ Prefer not to say
- ◯ Other

Does your gender match your gender assigned at birth? *

- ◯ Yes
- ◯ No

If applicable, are you pregnant? *

- ◯ Yes
- ◯ No

- ○ N/A

If applicable, are you 6 months or less postpartum? *

- ○ Yes
- ○ No
- ○ N/A

If applicable, do you have periods/a menstrual cycle? *

- ○ Yes
- ○ No, post-menopausal
- ○ No, other reason
- ○ N/A

Which of the following best describes your ancestry? Select all that apply. *

- ☐ Asian, South Asian, South East Asian (Chinese, Asian Indian, Vietnamese, Filipino...)
- ☐ Black (African American, Jamaican, Nigerian, Haitian...)
- ☐ White (German, Italian, English, Polish, French...)
- ☐ Hispanic, Latino, or Spanish Origin (Mexican, Mexican American, Puerto Rican, Cuban...)
- ☐ Indigenous Peoples (Navajo Nation, Blackfeet Tribe, Mayan, Inupiat...)
- ☐ Pacific Islander (Native Hawaiian, Samoan, Fujian, Chamorro...)
- ☐ Middle Eastern, North African (Lebanese, Iranian, Egyptian, Moroccan...)
- ☐ Prefer not to answer

☐ Other

What was your household annual income immediately **BEFORE COVID-19**? *

- ◯ $0 - $10,000 USD
- ◯ $10,001 - $40,000 USD
- ◯ $40,001 - $85,000 USD
- ◯ $85,001 - $150,000 USD
- ◯ >$150,000 USD
- ◯ Prefer not to answer

What is your household annual income now, **AFTER COVID-19**? *

- ◯ $0 - $10,000 USD
- ◯ $10,001 - $40,000 USD
- ◯ $40,001 - $85,000 USD
- ◯ $85,001 - $150,000 USD
- ◯ >$150,000 USD
- ◯ Prefer not to answer

What was your household annual income immediately **BEFORE COVID-19**? *

- ◯ $0 - $10,000 CAD
- ◯ $10,001 - $40,000 CAD
- ◯ $40,001 - $85,000 CAD

- ◯ $85,001 - $150,000 CAD
- ◯ >$150,000 CAD
- ◯ Prefer not to answer

What is your household annual income now, **AFTER COVID-19**? *

- ◯ $0 - $10,000 CAD
- ◯ $10,001 - $40,000 CAD
- ◯ $40,001 - $85,000 CAD
- ◯ $85,001 - $150,000 CAD
- ◯ >$150,000 CAD
- ◯ Prefer not to answer

What is your household annual income, **BEFORE COVID-19**? *

- ◯ £0 - £20,000 GBP
- ◯ £20,000 - £40,000 GBP
- ◯ £40,000 - £60,000 GBP
- ◯ £60,000 - £80,000 GBP
- ◯ >£80,000 GBP
- ◯ Prefer not to answer

What is your household annual income, **AFTER COVID-19**? *

- ◯ £0 - £20,000 GBP
- ◯ £20,000 - £40,000 GBP
- ◯ £40,000 - £60,000 GBP
- ◯ £60,000 - £80,000 GBP

- ◯ >£80,000 GBP
- ◯ Prefer not to answer

What is your household annual income, **BEFORE COVID-19**? *

- ◯ €0 - €20,000 EUR
- ◯ €20,000 - €40,000 EUR
- ◯ €40,000 - €60,000 EUR
- ◯ €60,000 - €80,000 EUR
- ◯ >€80,000 EUR
- ◯ Prefer not to answer

What is your household annual income, **AFTER COVID-19**? *

- ◯ €0 - €20,000 EUR
- ◯ €20,000 - €40,000 EUR
- ◯ €40,000 - €60,000 EUR
- ◯ €60,000 - €80,000 EUR
- ◯ >€80,000 EUR
- ◯ Prefer not to answer

What is your highest educational level achieved? *

- ◯ Some high school or less
- ◯ High school graduate
- ◯ Baccalaureate/undergraduate degree
- ◯ Graduate degree

Are you a healthcare professional? *

- ○ Yes
- ○ No

How did you find this survey? *

- ☐ Body Politic Slack Group
- ☐ Long Haul COVID Fighters Group on Facebook
- ☐ Long Covid Support Group on Facebook
- ☐ Other support group
- ☐ Facebook
- ☐ Twitter
- ☐ Instagram
- ☐ Friend/Family shared it with me
- ☐ Patient Led Research mailing list
- ☐ Media (article, newspaper, blog)
- ☐ Other

Background Section

When did your symptoms begin? *

	Month	Day	Year
Please Select:			2020

Are you still experiencing symptoms? *

- ○ Yes
- ○ No

Recovered - Total Days

How many days total did you experience symptoms? *

Lifestyle & Pre-existing Conditions

Did you have any of these **pre-existing** conditions/diagnoses or did you experience any of the following pre-COVID?

- ☐ Food Allergies
- ☐ Environmental Allergies (dust, mold)
- ☐ Chemical Allergies
- ☐ Seasonal Allergies
- ☐ Allergies of unknown origin
- ☐ Other allergies
- ☐ Insomnia
- ☐ Lucid dreams (dreams where you are aware you are dreaming or have some control over what you dream)
- ☐ Nightmares
- ☐ Vivid dreams
- ☐ Night sweats
- ☐ Sleep apnea
- ☐ Acid Reflux Disease
- ☐ Celiac Disease

- [ ] Crohn's Disease
- [ ] Ulcerative Colitis
- [ ] Irritable Bowel Syndrome (IBS)
- [ ] Other GI issues
- [ ] Asthma
- [ ] COPD
- [ ] Tuberculosis
- [ ] Eczema
- [ ] Viral skin conditions (cold sores, herpes, warts, molluscum)
- [ ] Dementia
- [ ] Seizures/epilepsy
- [ ] Migraine
- [ ] ALS
- [ ] Parkinson's disease
- [ ] Multiple Sclerosis
- [ ] Peripheral neuropathy
- [ ] Coronary Heart Disease
- [ ] Heart failure
- [ ] Hypertension (high blood pressure)
- [ ] Hypotension (low blood pressure)
- [ ] History of clotting
- [ ] History of strokes
- [ ] High cholesterol / hyperlipidemia
- [ ] Mitral valve prolapse
- [ ] Anemia
- [ ] Autism
- [ ] Auto-immune/rheumatological conditions
- [ ] Cancer (all types)
- [ ] Chronic kidney disease
- [ ] Diabetes Type 1
- [ ] Diabetes Type 2

- [ ] Ehlers-Danlos Syndrome (EDS)
- [ ] Endometriosis
- [ ] Fibromyalgia
- [ ] IgA deficiency
- [ ] Interstitial Cystitis (Bladder Pain Syndrome)
- [ ] Hepatitis (A/B/C)
- [ ] HIV
- [ ] Mast Cell Activation Syndrome (MCAS)
- [ ] Myalgic Encephalomyelitis / Chronic Fatigue Syndrome (ME/CFS)
- [ ] Obesity
- [ ] Postural Orthostatic Tachycardia Syndrome (POTS)
- [ ] Recurrent bacterial infections
- [ ] Recurrent viral infections
- [ ] Restless leg syndrome
- [ ] TMJ (temporomandibular joint dysfunction)
- [ ] Vertigo
- [ ] Vision: near-sighted/far-sighted
- [ ] Vitamin D deficiency
- [ ] **None of the above**

Please indicate other pre-existing conditions/diagnoses not listed here. If multiple, please separate them with a comma. Please only list the conditions, no descriptions or explanations.

Did any of your pre-existing conditions change during the course of

your COVID19 symptoms?

- ◯ Yes, they got worse.
- ◯ Yes, they got better.
- ◯ Some got better, some stayed the same, some got worse (please add an explanation in the text boxes in the following page).
- ◯ No, they stayed the same.
- ◯ N/A (I did not have any pre-existing condition)

If any of your pre-existing conditions got worse, please describe here. (optional)

If any of your pre-existing conditions got better, please describe here. (optional)

What is your blood type? If you don't know, please select 'Don't know'. *

Don't know

Hospitalization

Hospitalization

Did you consult with a physician(s) for your COVID symptoms? Select all that apply. This can include both in-person appointments and telemedicine, like phone calls. *

- [ ] Alternative Medicine doctor
- [ ] Cardiologist
- [ ] Dermatologist
- [ ] Gastroenterologist
- [ ] Hematologist
- [ ] Hospitalist
- [ ] Immunologist/Allergist
- [ ] Infectious disease specialist
- [ ] My primary care doctor/General practitioner
- [ ] Neurologist/Neuroimmunologist
- [ ] Obstetrician-Gynecologist (OB-GYN)
- [ ] Psychiatrist
- [ ] Pulmonologist
- [ ] Rheumatologist
- [ ] Other
- [ ] I have not seen any physician

Were you hospitalized? *

- ◯ Yes
- ◯ No
- ◯ I visited ER/Urgent care but was not admitted/did not stay overnight at a hospital

If yes: how long were you hospitalized for? [Number of days] *

Did you receive oxygen support in the hospital? *

- ◯ Yes, nasal cannula
- ◯ Yes, I was intubated
- ◯ No
- ◯ I was not hospitalized
- ◯ Other

(Optional) If you'd like, please describe your experience with medical care.

COVID-19 Testing

Were you tested for COVID-19 using a Swab test? (This is not asking about antibody tests, which are covered in a separate section of the survey.) *

- ◯ Yes, I was tested at least once.
- ◯ No, I tried to get tested but was unable.
- ◯ No, I did not try to get tested.

How many times were you tested (Swab test) *

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ Other

On what date did you first get tested? (if you don't remember the exact date, enter an estimate) *

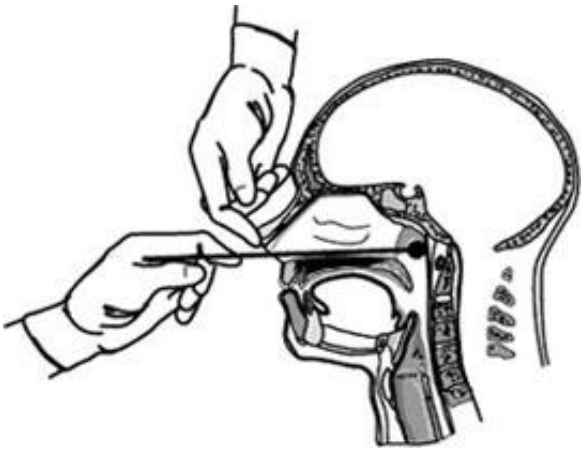
	Month	Day	Year
Please Select:			2020

Was this an estimated date?

- ☐ This was an estimate

What was the type of your first COVID-19 test?

- [ ] Nasal (nasal secretions from nostrils, without moving forward into the back of the nose and throat)
- [ ] Nasopharyngeal (nasal secretions from end of the nostrils, by moving to the cavity in back of the nose and throat)



- [ ] Throat
- [ ] Other

What was the status of your test? *

- ◯ Positive
- ◯ Negative
- ◯ Inconclusive/Awaiting results

On what date were your tested the second time? (if you don't remember the exact date, enter an estimate) *

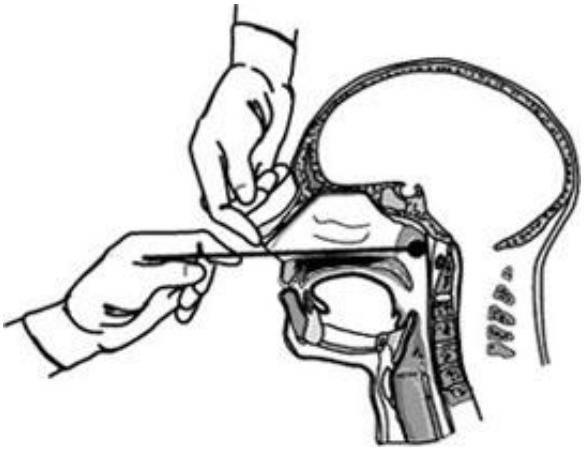
	Month	Day	Year
Please Select:			2020

Was this an estimated date?

- [ ] This was an estimate

What was the type of your second COVID-19 test?

- [ ] Nasal (nasal secretions from nostrils, without moving forward into the back of the nose and throat)
- [ ] Nasopharyngeal (nasal secretions from end of the nostrils, by moving to the cavity in back of the nose and throat)



- [ ] Throat
- [ ] Other

What was the status of your test? *

- ○ Positive
- ○ Negative
- ○ Inconclusive/Awaiting results

On what date were you tested the third time? (if you don't remember the exact date, enter an estimate) *

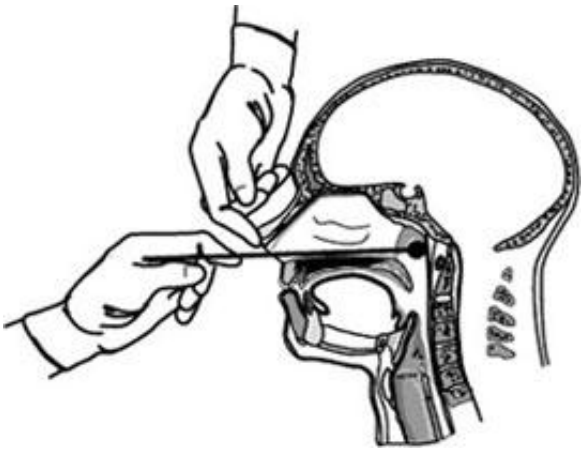
	Month	Day	Year
Please Select:			2020

Was this an estimated date?

- [ ] This was an estimate

What was the type of your third COVID19 test?

- [ ] Nasal (nasal secretions from nostrils, without moving forward into the back of the nose and throat)
- [ ] Nasopharyngeal (nasal secretions from end of the nostrils, by moving to the cavity in back of the nose and throat)



- [ ] Throat
- [ ] Other

What was the status of your test? *

- ◯ Positive
- ◯ Negative
- ◯ Inconclusive/Awaiting results

If you had any other tests, please list them here. Please put each test on a new line with the type, date, and status separated by a comma. For example: Nasopharyngeal, 4-1-20, Positive. If you do not remember the exact date, please enter the closest date possible

Antibody Testing

Did you receive an antibody test? *

- ◯ Yes, I was tested at least once for antibodies
- ◯ No, I was NOT tested at all for antibodies

How many times were you tested for antibodies? *

What was your antibody test result? *

- ◯ I tested positive for both (IgG and IgM) antibodies
- ◯ I only tested positive for IgM antibodies
- ◯ I only tested positive for IgG antibodies
- ◯ I don't know the antibodies type but I tested positive.
- ◯ I tested negative for antibodies

If you tested positive and your test included a titer value, what was the value for IgM?

If you tested positive and your test included a titer value, what was the value for IgG?

What type of test was it? *

- ◯ Blood Draw
- ◯ Blood Finger Prick

Enter the date of the antibody test (if you don't remember the exact date, enter an estimate). *

	Month	Day	Year
Please Select:			2020

Was this an estimated date?

☐ This was an estimated date

Who was the manufacturer of the test? (Please only select the specific manufacturer if you are certain. Otherwise select "I don't know.") *

- ○ Abbott
- ○ Roche
- ○ Mt. Sinai
- ○ EuroImmun
- ○ Ortho-Clinical Diagnostics Vitros
- ○ DiaSorin
- ○ I don't know

Do you have another antibody test to report? *

- ○ Yes
- ○ No

What was your antibody test result? *

- ○ I tested positive for both (IgG and IgM) antibodies
- ○ I only tested positive for IgM antibodies
- ○ I only tested positive for IgG antibodies
- ○ I don't know the antibodies type but I tested positive.
- ○ I tested negative for antibodies

If you tested positive and your test included a titer value, what was the value (in mg/dL) for IgM? *

If you tested positive and your test included a titer value, what was the value (in mg/dL) for IgG? *

What type of test was it? *

- ◯ Blood Draw
- ◯ Blood Finger Prick

Enter the date of the antibody test (if you don't remember the exact date, enter an estimate). *

	Month	Day	Year
Please Select:			2020

Was this an estimated date?

- ☐ This was an estimated date

Who was the manufacturer of the test? (Please only select specific manufacturer if you are certain. Otherwise select "I don't know.") *

- ◯ Abbott
- ◯ Roche
- ◯ Mt. Sinai
- ◯ EuroImmun
- ◯ Ortho-Clinical Diagnostics Vitros
- ◯ DiaSorin
- ◯ I don't know

Do you have another antibody test to report? *

- ◯ Yes
- ◯ No

What was your antibody test result? *

- ◯ I tested positive for both (IgG and IgM) antibodies
- ◯ I only tested positive for IgM antibodies
- ◯ I only tested positive for IgG antibodies
- ◯ I don't know the antibodies type but I tested positive.
- ◯ I tested negative for antibodies

If you tested positive and your test included a titer value, what was the value for IgM? *

☐

If you tested positive and your test included a titer value, what was the value for IgG? *

What type of test was it? *

- ◯ Blood Draw
- ◯ Blood Finger Prick

Enter the date of the antibody test (if you don't remember the exact date, enter an estimate). *

	Month	Day	Year
Please Select:			2020

Was this an estimated date?

- ☐ This was an estimated date

Who was the manufacturer of the test? (Please only select specific manufacturer if you are certain. Otherwise select "I don't know.") *

- ◯ Abbott
- ◯ Roche
- ◯ Ortho-Clinical Diagnostics Vitros
- ◯ DiaSorin

- ○ Mt. Sinai
- ○ EuroImmun
- ○ I don't know

Symptoms

Memory Symptoms

Have you experienced any **MEMORY RELATED SYMPTOMS** since the start of your COVID-19 illness? *

- ○ Yes
- ○ No

Which of the following memory symptoms have you experienced since the start of your COVID-19 illness? *

- ☐ Short-term memory loss (memory that lasts ~30 seconds, i.e. remembering a phone number before writing it down, or forgetting you're in the middle of a task)
- ☐ Long-term memory loss (long-term memory can be anything from remembering yesterday, forgetting you've done a task, forgetting recently learned information, or forgetting your third-grade experience)
- ☐ Not being able to make new memories
- ☐ Forgetting how to do routine tasks (tying your shoe laces, washing your hands)
- ☐ None of the above
- ☐ Other

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	Week 1	Week 2	Week 3	Week 4	**Month 2**	Month 3	Month 4	Month 5	Month 6
Memory symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐

Cognitive Function/Brain Fog Symptoms

Have you experienced issues with **BRAIN FOG** (inability to focus, think clearly, plan, process, understand, and maintain a coherent stream of thought; abnormally slow or fast thoughts) since the start of your COVID-19 illness? *

- ○ Yes
- ○ No

Which of the following brain fog/cognitive functioning symptoms have you experienced since the start of your COVID-19 illness? *

- ☐ Difficulty with executive functioning (planning, organizing, figuring out the sequence of actions, abstracting)
- ☐ Agnosia (failure to recognize or identify objects despite intact sensory functioning)
- ☐ Difficulty problem-solving or decision-making

- [ ] Difficulty thinking
- [ ] Thoughts moving too quickly
- [ ] Slowed thoughts
- [ ] Poor attention or concentration
- [ ] I did NOT have any Brain Fog symptoms
- [ ] Other

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if you haven't yet reached a week/month, please leave it blank). Even if you have only experienced these symptoms for part of a week or month, please select it.

	Week 1	Week 2	Week 3	Week 4	**Month 2**	Month 3	Month 4	Month 5	Month 6
Brain fog/cognitive functioning symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐

Changes to Daily/Functional Abilities due to memory loss or brain fog

Have you felt significantly limited or unable to do any of the following due to **MEMORY LOSS OR BRAIN FOG** (including issues with attention, cognitive functioning, and awareness) specifically? *

	Severely unable	Moderately unable	Mildly unable	Able	apl

Drive	○	○	○	○	
Watch children	○	○	○	○	
Cook or use hot items	○	○	○	○	
Feed yourself	○	○	○	○	
Shower or bathe regularly	○	○	○	○	

	Severely unable	Moderately unable	Mildly unable	Able	apl
Make serious decisions	○	○	○	○	
Leave the house and return without getting lost	○	○	○	○	
Remember the correct month or year	○	○	○	○	
Have conversations with others	○	○	○	○	
Maintain your medication schedule (forgetting to take medication or forgetting you've taken medication)	○	○	○	○	

	Severely unable	Moderately unable	Mildly unable	Able	apl
Work	○	○	○	○	
Follow simple instructions	○	○	○	○	
Communicate your thoughts and needs	○	○	○	○	

Other

	○	○	○	○	

	Severely unable	Moderately unable	Mildly unable	Able	apl

Optional: If you have other areas of your life that were affected by

memory loss or brain fog, please include them here. Please note whether they were mildly, moderately, or severely limiting.

Optional: Please use this space to describe examples of your brain fog, memory loss, and attention span.
Please do not include any identifying information (such as name or location).

Emotional/Behavioral Changes

Emotional and Behavioral Changes

Compared to how you felt before COVID, have you experienced an increase in any of the following? *

- [ ] Difficulty controlling your emotions
- [ ] Lack of inhibition (difficulty controlling your behavior)

- [ ] Irritability
- [ ] Anger
- [ ] Impulsivity (acting on a whim without self-control)
- [ ] Aggression
- [ ] Euphoria (a feeling or state of intense excitement and happiness)
- [ ] Delusions
- [ ] Depression
- [ ] Apathy (lack of feeling, emotion, interest, or concern)
- [ ] Suicidality
- [ ] Mood swings
- [ ] Anxiety
- [ ] Mania (abnormally elevated/excited mood, decreased need for sleep, occasionally with delusions)
- [ ] Hypomania (a milder form of mania)
- [ ] Tearfulness
- [ ] Sense of doom
- [ ] None of the above
- [ ] Other

Optional: Please use this space to describe examples of your emotional changes during your illness.
Please do not include any identifying information (name, location, etc.).

Optional: If you had any of these emotional experiences **pre**-COVID,

please describe how they differed **post**-COVID.

Please do not include any identifying information (name, location, etc.).

Speech and Other Language Issues

Speech and Language Issues

Have you experienced any issues with **SPEECH AND LANGUAGE** since the start of your COVID-19 illness? *

- ◯ Yes
- ◯ No

Which of the following speech and language symptoms have you experienced since the start of your COVID-19 illness? *

- ☐ Difficulty finding the right words while speaking/writing
- ☐ Difficulty communicating verbally
- ☐ Difficulting speaking in complete sentences
- ☐ Speaking unrecognizable words
- ☐ Difficulty communicating in writing
- ☐ Difficulty processing/understanding what others say

- [ ] Difficulty reading/processing written text
- [ ] (If applicable) changes to your non-primary (second/third) language skills
- [ ] None of the above
- [ ] Other

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	Week 1	Week 2	Week 3	Week 4	**Month 2**	Month 3	Month 4	Month 5	M
Speech/language issues	☐	☐	☐	☐	☐	☐	☐	☐	

Do you speak multiple languages? *

- ○ Yes
- ○ No

Optional: Please use this space to describe examples of your language issues, including speech, writing, reading, and listening to words. Please include any changes to your speech/language that are not mentioned above. For instance, if you speak multiple languages and have noticed different problems with your primary and non-primary

language.

Headaches

Headaches

Have you experienced any new **HEADACHES OR RELATED ISSUES** since the start of your COVID-19 illness? *

- ◯ Yes
- ◯ No

Which of the following symptoms have you experienced since the start of your COVID-19 illness? *

- ☐ Headaches, at the base of the skull
- ☐ Headaches, in the temples
- ☐ Headaches, behind the eyes
- ☐ Headaches, diffuse (entire brain)
- ☐ Headaches/pain after mental exertion
- ☐ Headaches, other
- ☐ Sensation of brain warmth/"on fire"

- [ ] Sensation of brain pressure
- [ ] Migraines
- [ ] Stiff neck
- [ ] None of the above

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	Week 1	Week 2	Week 3	Week 4	**Month 2**	Month 3	Month 4	Month 5	Month 6
Headaches and related symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐

Sense of Smell and Taste

Sense of Smell and Taste

Have you experienced any changes to your **SENSE OF SMELL OR TASTE** since the start of your COVID-19 illness? *

- ◯ Yes
- ◯ No

Which of the following symptoms have you experienced since the start of your COVID-19 illness? *

- [ ] Loss of smell
- [ ] Phantom smells (imagining/hallucinating smells - smelling things that aren't there)
- [ ] Heightened sense of smell
- [ ] Altered sense of smell
- [ ] Loss of taste
- [ ] Phantom taste (imagining/hallucinating tastes - tasting things when there's nothing in your mouth)
- [ ] Heightened sense of taste
- [ ] Altered sense of taste
- [ ] None of the above

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	Week 1	Week 2	Week 3	Week 4	**Month 2**	Month 3	Month 4	Month 5	Month 6	M
Changes to sense of smell and taste	☐	☐	☐	☐	☐	☐	☐	☐	☐	

If you had phantom tastes, please describe them:

If you had phantom smells, please describe them:

Tremors and Vibrating Sensations

Tremors and Vibrating Sensations

Have you experienced any **TREMOR OR VIBRATION SENTATIONS** since the start of your COVID-19 illness? *

Tremor: Involuntary, rhythmic muscle contraction leading to shaking movements in one or more parts of the body
Vibration sensation: A buzzing feeling, when you feel like your muscles, fingers, or legs are vibrating or shaking inside, but you don't see the movement

- ◯ Yes
- ◯ No

Which of the following symptoms have you experienced since the start of your COVID-19 illness? *

Please specify the location on your body in the text box. If multiple locations, please separate them with a comma (i.e. leg, torso, hand).

☐ _____ Tremors

☐ _____ Vibrating sensations

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	N/A	**Week 1**	Week 2	Week 3	Week 4	**Month 2**	Month 3	Month 4	Month 5	M
Tremors	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Vibrating Sensations	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Please use this space to describe examples of your tremors or body vibration/shaking during your illness.
Please do not include any identifying information (such as name or location).

Sleeping issues

Sleeping issues

Have you experienced any **SLEEPING ISSUES** since the start of your COVID-19 illness? *

- ○ Yes
- ○ No

Which of the following sleeping issues have you experienced since the start of your COVID-19 illness? *

- ☐ Lucid dreams (dreams where you are aware you are dreaming or have some control over what you dream about)
- ☐ Vivid dreams
- ☐ Nightmares
- ☐ Insomnia
- ☐ Night sweats
- ☐ Restless leg syndrome
- ☐ Awakened by feeling like you couldn't breathe
- ☐ Sleep apnea

☐ Other

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Month 5	M
Insomnia	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Sleep apnea	☐	☐	☐	☐	☐	☐	☐	☐	☐	
All the other sleeping symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐	

If you have/had insomnia, which best describes the type of insomnia? *

- ☐ Difficulty falling asleep
- ☐ Waking up early in the morning
- ☐ Waking up several times during the night
- ☐ None of the above

What is causing/caused your insomnia? *

- ☐ Pain

- [ ] Sensitivity to outside light/noise
- [ ] Other physical discomfort
- [ ] Anxiety/depression/racing thoughts
- [ ] Difficulty breathing
- [ ] A sensation of adrenaline/energy
- [ ] A sensation like the virus was keeping me awake
- [ ] Other

Hallucinations

Hallucinations

Have you experienced any **HALLUCINATIONS** (visual, hearing, or touch) since the start of your COVID-19 illness? *

- ○ Yes
- ○ No

Which of the following hallucinations have you experienced since the start of your COVID-19 illness? *

- [ ] Visual (seeing) Hallucinations
- [ ] Auditory (hearing) Hallucinations
- [ ] Tactile (touch) Hallucinations
- [ ] Hallucinations, other

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if you haven't yet reached a week/month, please leave it blank). Even if you have only experienced these symptoms for part of a week or month, please select it.

	Week 1	Week 2	Week 3	Week 4	**Month 2**	Month 3	Month 4	Month 5	Mont 6
Hallucinations	☐	☐	☐	☐	☐	☐	☐	☐	☐

Weakness, numbness, tingling, coldness, and other sensations

Weakness, numbness, tingling, coldness, and other sensations

Which of the following **NEUROLOGICAL SENSATION SYMPTOMS** have you experienced since the start of your COVID-19 illness, if any? *

Please specify the location on your body in the text box. If multiple locations, please separate them with a comma (i.e. hand, leg, foot).

- ☐ Skin sensations: burning, tingling, or itchiness without rash
- ☐ [ ] Numbness/loss of sensation
- ☐ Numbness/weakness on one side of the body only

- [ ] Coldness
- [ ] Tingling/prickling/pins and needles sensation
- [ ] Electrical zaps/electrical shock sensation
- [ ] Facial paralysis (please indicate where on face was paralyzed)
- [ ] Sensation of facial pressure/numbness, left side
- [ ] Sensation of facial pressure/numbness, right side
- [ ] Sensation of facial pressure/numbness, other:
- [ ] Weakness
- [ ] None of the above

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Month 5
All neurological sensations	☐	☐	☐	☐	☐	☐	☐	☐	☐

Temperature Issues

Temperature Issues

Have you experienced any **TEMPERATURE ISSUES** (including heat intolerance, chills, high/low temperature) since the start of your COVID-19 illness? *

- ◯ Yes
- ◯ No

Did you experience any of the following **TEMPERATURE ISSUES** since the start of your COVID-19 illness? *

- ☐ Temperature lability (quick swings in and out of fever or elevated temperature)
- ☐ Heat intolerance
- ☐ Other temperature issues (not listed above or below)

If you experienced any of the following temperature issues, when did you experience the following symptoms? *

Please mark symptoms for the first 4 weeks, then months (if you haven't yet reached a week/month, please leave it blank). Even if you have only experienced these symptoms for part of a week or month, please select it.

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4
Elevated temperature (98.8-100.4 degrees Fahrenheit, 37.1-37.9 Celsius)	☐	☐	☐	☐	☐	☐	☐	☐
Fever (100.4 degrees Fahrenheit / 38 degrees Celsius or above)	☐	☐	☐	☐	☐	☐	☐	☐
Low temperature	☐	☐	☐	☐	☐	☐	☐	☐
Chills/flushing/sweats	☐	☐	☐	☐	☐	☐	☐	☐
All other temperature issues	☐	☐	☐	☐	☐	☐	☐	☐

If you had a low temperature, what was your lowest temperature? Please input number only.

☐

If you had a high temperature, what was your highest temperature? Please input number only.

☐

Cardiovascular Symptoms

Cardiovascular Symptoms

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable), even if you have only experienced these symptoms for part of a week or month.

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Mont 5
Tachycardia (high heart rate, >90 beats per minute)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bradycardia (low heart rate, <60 beats per minute)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart palpitations (sensation or awareness of your heart beating. Feeling like your heart is racing, thumping or skipping beats)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abnormally high blood pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abnormally low blood pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
Visibly inflamed/bulging veins	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fainting	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood clots (Thrombosis)	☐	☐	☐	☐	☐	☐	☐	☐	☐

If you had tachycardia and were able to measure it, what was the maximum heart rate (in bpm) that you measured, **at rest**?

If you had tachycardia and were able to measure it, what was the maximum heart rate (in bpm) that you measured, **at exertion** (during physical activity)?

If you had tachycardia and were able to measure it, was your heart rate higher when standing compared to sitting?

- ◯ Yes, it was higher when I was standing
- ◯ No, it was higher when I was sitting
- ◯ It was about the same while standing or sitting

If you had tachycardia and were able to measure it, how much did your heart rate generally change from lying position to standing, last time you measured? (In BPM, beats per minute)

All Other Symptoms - Timecourse

This section has multiple groups of questions about multiple symptoms/issues organized by body area (**Generic Issues, Gastrointestinal issues, Respiratory and sinus symptoms, ear/hearing symptoms, eye symptoms, Reproductive and urinary symptoms, skin and allergy symptoms, and muscle and joint issues**)

Did you experience these symptoms, and when did you experience them? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it. **If you experienced none of the symptoms in a set, select the checkbox (None of the below issues apply to me) above the grouped set.**

Generic Issues

☐ None of the below generic symptoms apply to me

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4
Dizziness / vertigo / unsteadiness or balance issues	☐	☐	☐	☐	☐	☐	☐	☐
Neuralgia (nerve pain)	☐	☐	☐	☐	☐	☐	☐	☐
Seizures (confirmed)	☐	☐	☐	☐	☐	☐	☐	☐
Seizures (suspected)	☐	☐	☐	☐	☐	☐	☐	☐
Episodes of breathing difficulty/gasping for air when your oxygen saturation is normal	☐	☐	☐	☐	☐	☐	☐	☐
Low oxygen levels (<94%)	☐	☐	☐	☐	☐	☐	☐	☐
New/unexpected anaphylaxis reaction	☐	☐	☐	☐	☐	☐	☐	☐
Acute (sudden) confusion/disorientation	☐	☐	☐	☐	☐	☐	☐	☐
Slurring words/speech	☐	☐	☐	☐	☐	☐	☐	☐
High blood sugar (if measured)	☐	☐	☐	☐	☐	☐	☐	☐
Low blood sugar (if measured)	☐	☐	☐	☐	☐	☐	☐	☐

Gastrointestinal Issues

☐ None of the below gastrointestinal symptoms apply to me

Gastrointestinal Issues

N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Mor 5

Constipation	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nausea	☐	☐	☐	☐	☐	☐	☐	☐	☐
Loss of Appetite	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abdominal pain	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower Esophagus Burning / gastroesophageal reflux / acid reflux	☐	☐	☐	☐	☐	☐	☐	☐	☐

Respiratory and Sinus Symptoms

☐ None of the below respiratory and sinus symptoms apply to me

Respiratory and Sinus Symptoms

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Mont 3
Dry cough	☐	☐	☐	☐	☐	☐	☐
Cough with mucus production	☐	☐	☐	☐	☐	☐	☐
Coughing up Blood	☐	☐	☐	☐	☐	☐	☐
Shortness of Breath	☐	☐	☐	☐	☐	☐	☐
Tightness of Chest	☐	☐	☐	☐	☐	☐	☐
Sneezing	☐	☐	☐	☐	☐	☐	☐
Runny nose	☐	☐	☐	☐	☐	☐	☐
Pain/burning in chest	☐	☐	☐	☐	☐	☐	☐

Rattling of breath	☐	☐	☐	☐	☐	☐	☐
Sore Throat	☐	☐	☐	☐	☐	☐	☐
Other ☐	☐	☐	☐	☐	☐	☐	☐

Ear and Hearing Symptoms

☐ None of the below ear and hearing symptoms apply to me

Ear and Hearing Symptoms

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Month 5	M
Hearing loss	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Tinnitus	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Other ear/hearing issues	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Eye and Vision Symptoms

☐ None of the below eye and vision symptoms apply to me

Eye and Vision Symptoms

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Month 5	M

Vision symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other eye symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Reproductive and Urinary Symptoms

☐ None of the below reproductive and urinary symptoms apply to me

Reproductive and Urinary Symptoms

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Mont 5
All menstrual/period issues	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bladder control issues	☐	☐	☐	☐	☐	☐	☐	☐	☐

Skin and Allergy Symptoms

☐ None of the below skin and allergy symptoms apply to me

Skin and Allergy Symptoms

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Mont 3
Peeling skin	☐	☐	☐	☐	☐	☐	☐

Petechiae (tiny purple, red, or brown spots on the skin, usually on arms, legs, stomach, buttocks, and occasionally inside mouth or on eyelids)	☐	☐	☐	☐	☐	☐	☐
COVID toes (discoloration, swelling, painful, or blistering toes)	☐	☐	☐	☐	☐	☐	☐
Dermatographia (writing on your skin causes red lines where you scratched)	☐	☐	☐	☐	☐	☐	☐
New allergies (food, chemical, environmental, etc)	☐	☐	☐	☐	☐	☐	☐
Skin rashes	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

Muscle and Joint issues

☐ None of the below muscle and joint symptoms apply to me

Muscle and Joint issues

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Month 5	Mon 6
Muscle spasms	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Muscle aches	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Joint pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bone ache or burning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

All Other Symptoms - Checkbox

All Other Symptoms

Have you experienced any of these symptoms since the start of your COVID-19 illness? *

(Please choose all options that apply)

- [ ] Inability to cry
- [ ] Inability to yawn
- [ ] Lump in throat/difficulty swallowing
- [ ] Changes in the voice
- [ ] Coughing up Blood
- [ ] Feeling like you aren't real/like you're observing yourself from outside your body (depersonalization)
- [ ] Feeling like the world isn't real (derealization)
- [ ] Extreme thirst
- [ ] None of the above

Ear and Hearing

- [ ] Ear pain
- [ ] Changes to the ear canal (such as pressure, blockage, burning, swelling)
- [ ] Numbness/loss of sensation
- [ ] Sensitivity to noise
- [ ] Other ear/hearing symptoms
- [ ] None of the above

Eye and Vision

- [ ] Vision symptoms - Blurred vision
- [ ] Vision symptoms - Double vision
- [ ] Vision symptoms - Sensitivity to light
- [ ] Vision symptoms - Tunnel vision
- [ ] Vision symptoms - Total loss of vision
- [ ] Eye pressure or pain
- [ ] Pink eye (conjunctivitis)
- [ ] Bloodshot eyes
- [ ] Dry eyes
- [ ] Redness on the outside of eyes
- [ ] Floaters
- [ ] Seeing things in your peripheral vision
- [ ] Other eye issues:
- [ ] None of the above

Reproductive and Urinary

- [ ] Early Menopause
- [ ] Post-Menopausal bleeding/spotting
- [ ] Abnormally heavy periods/clotting
- [ ] Abnormally irregular periods
- [ ] Other menstrual issues
- [ ] Decrease in size of testicles/penis
- [ ] Pain in testicles

- [ ] Other semen/penis/testicles issues
- [ ] Sexual dysfunction (difficulty maintaining erection, vaginal dryness, difficulty orgasming)
- [ ] Urinary issues, other
- [ ] None of the above

Gastrointestinal

- [ ] Feeling full quickly when eating
- [ ] Abdominal pain
- [ ] Hyperactive bowel sensations
- [ ] None of the above

Skin and Allergy

- [ ] New allergies (food, chemical, environmental, etc)
- [ ] Heightened reaction to old allergies
- [ ] Itchy skin
- [ ] Itchy eyes
- [ ] Itchy, other
- [ ] Brittle/discolored nail
- [ ] Shingles
- [ ] None of the above

Symptom Course

How severe were/are your symptoms over the course of the weeks/months? *

If you experienced multiple severities for symptoms within the time period, select the most severe within that time period.

	No symptom	Very Mild	Mild	Moderate	Severe	Very Severe
Week 1	○	○	○	○	○	○
Week 2	○	○	○	○	○	○
Week 3	○	○	○	○	○	○
Week 4	○	○	○	○	○	○
Month 2	○	○	○	○	○	○

	No symptom	Very Mild	Mild	Moderate	Severe	Very Severe
Month 3	○	○	○	○	○	○
Month 4	○	○	○	○	○	○
Month 5	○	○	○	○	○	○
Month 6	○	○	○	○	○	○
Month 7+	○	○	○	○	○	○

	No symptom	Very Mild	Mild	Moderate	Severe	Very Severe

Which of these descriptions appropriately describes your experience with relapses, and your symptom course overall? Please select all that apply: *

☐ I don't experience relapses/have not yet experienced relapses.

- [ ] My relapses happen in a regular pattern (monthly, daily, or weekly).
- [ ] My relapses happen in an irregular pattern (randomly).
- [ ] My relapses happen in response to a trigger (stress, alcohol, exercise/exertion, etc).
- [ ] My relapses are getting shorter/easier over time.
- [ ] My relapses are getting longer/harder over time.
- [ ] My relapse severity has stayed about the same over time.
- [ ] Overall, my symptoms have slowly gotten better over time.
- [ ] Overall, my symptoms have stayed about the same over time.
- [ ] Overall, my symptoms have slowly worsened over time.
- [ ] I got worse rapidly.
- [ ] I got better rapidly.
- [ ] Other

Which of these trigger a relapse or worsening of symptoms? Please select all that apply: *

- [ ] Stress
- [ ] Alcohol
- [ ] Caffeine
- [ ] Heat
- [ ] Period/menstruation
- [ ] Week before period/menstruation
- [ ] Exercise
- [ ] Physical activity
- [ ] Mental activity
- [ ] Other

How would you rate how you feel today, on a scale of 0-100% (with 100% being your pre-COVID baseline)?

0 10 20 30 40 50 60 70 80 90 100

%

Symptom Severity

List at least **three symptoms** that have been the most debilitating during recovery.
On a scale of 0-10, how severe have they been? (0 is completely fine, 10 is completely debilitating).

0 1 2 3 4 5 6 7 8 9 10

Symptom 1 *

Symptom 2 *

Symptom 3 *

Symptom 4

Symptom 5

Post-Exertional Malaise (effects of physical and mental activity on symptoms)

Post-Exertional Malaise

Worsening or relapse of symptoms after physical and/or mental activity

During your COVID-19 recovery, have you experienced any worsening or relapse of your symptoms after physical activity or mental activity? *

- ◯ Yes
- ◯ No

How strongly have you experienced worsening/relapse of your symptoms, on average? Please keep the slider at 0 if you did not experience this. *

	No post-exertional malaise			Some post-exertional malaise				Strong post-exersional malaise		
	0	1	2	3	4	5	6	7	8	9	10
Physical											
Cognitive											

If you have experienced worsening or a relapse after **Physical** Activity, when does the worsening/relapse of symptoms happen? *

- [ ] Immediately
- [ ] The same day, after a few hours
- [ ] The following day
- [ ] A couple of days later
- [ ] It varies
- [ ] I do not experience worsening/relapse of symptoms after Physical Activity

If you have experienced worsening or a relapse after **Mental** Activity, when does the worsening/relapse of symptoms happen? *

- [ ] Immediately
- [ ] The same day, after a few hours
- [ ] The following day
- [ ] A couple of days later
- [ ] It varies
- [ ] I do not experience worsening/relapse of symptoms after Mental Activity

How long does the worsening/relapse of symptoms usually last following Physical or Mental Activity? *

- [ ] Few hours
- [ ] Few days

☐ Few weeks

☐ Other

(Optional) Please explain anything else you'd like to share about your experience with Post-Exertional Malaise. For instance, you can list the type of activities that worsens your symptoms strongest (walking, strenuous exercise, reading, watching movies, etc).

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	Week 1	Week 2	Week 3	Week 4	**Month 2**	Month 3	Month 4	Month 5
Worsening/relapses of symptoms from physical and mental exertion	☐	☐	☐	☐	☐	☐	☐	☐

Fatigue Assessment Scale

Fatigue

The following ten statements refer to how you feel at the **current** stage of your COVID-19 recovery (over the past week). **Please give an answer to each question, even if you do not have any complaints at the moment.** *

	Never	Sometimes	Regularly	Often	Always
I am bothered by fatigue	○	○	○	○	○
I get tired very quickly	○	○	○	○	○
I don't do much during the day	○	○	○	○	○
I have enough energy for everyday life	○	○	○	○	○
Physically, I feel exhausted	○	○	○	○	○

	Never	Sometimes	Regularly	Often	Always
I have problems starting things	○	○	○	○	○
I have problems thinking clearly	○	○	○	○	○
I feel no desire to do anything	○	○	○	○	○
Mentally, I feel exhausted	○	○	○	○	○
When I am doing something, I can concentrate quite well	○	○	○	○	○

Compared to how you felt before contracting COVID-19, how would you describe your level of fatigue **during** COVID recovery? *

- ◯ Significantly more than pre-COVID
- ◯ Moderately more than pre-COVID
- ◯ Slightly more than pre-COVID
- ◯ Same as pre-COVID
- ◯ Less than pre-COVID

How much DAILY rest are/were you able to get on average, DURING your COVID-19 recovery? (Rest means time recovering/relaxing without work, childcare, or other obligations). Please do not include your daily sleep, or naps. *

- ◯ less than 2hrs per day
- ◯ 2-4hrs
- ◯ 4-6hrs
- ◯ 6-8hrs
- ◯ more than 8 hours per day

If you experienced fatigue, when did you feel fatigue? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	N/A	**Week 1**	Week 2	Week 3	Week 4	**Month 2**	Month 3	Month 4	Month 5	Mont 6
Fatigue	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Changes in Sensitivity to Medication or Other Substances

Changes in Sensitivity to Medication or Other Substances

Did you experience issues with changes in sensitivity to medication or other substances? *

- ◯ Yes
- ◯ No

What medication(s) or substance(s)? If multiple, please separate with a comma.

If medication, what do you take this for?

Please describe the changes you noticed:

General Functioning

In general, would you say your health BEFORE the onset of COVID was: *

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

In general, would you say your health CURRENTLY is: *

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

Does your health currently limit your ability to climb several flights of stairs? *

- ◯ Yes, limited a lot
- ◯ Yes, limited a little

- ◯ No, not limited at all

Does your health currently limit your ability to walk one block? *

- ◯ Yes, limited a lot
- ◯ Yes, limited a little
- ◯ No, not limited at all

Does your health currently limit your ability to bathe or dress yourself? *

- ◯ Yes, limited a lot
- ◯ Yes, limited a little
- ◯ No, not limited at all

During the last 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your **physical health**? (check all that apply) *

- ☐ Accomplished less than you would like
- ☐ Were limited in the kind of work or other activities
- ☐ Not limited

During the last 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your **emotional health**? (check all that apply) *

- [ ] Accomplished less than you would like
- [ ] Were limited in the kind of work or other activities
- [ ] Not limited

Mental Health

Mental Health Symptoms

You may choose not to answer any of questions.

If you are having suicidal thoughts, these free helplines are available 24/7 to offer support:

US: 1-800-273-8255 (Crisis Text Line: text TALK to 741741)

UK: 116 123

Netherlands: 0800 0113

Canada: 833-456-4566

Find additional crisis lines for your country

Have you ever (before COVID-19 symptoms) been diagnosed with a mental health condition (e.g. depression, anxiety, panic disorder, psychosis, etc.)?

- ◯ Yes
- ◯ No

Do you believe you have or have had a mental health condition that has not been diagnosed?

- ○ Yes
- ○ No

If you answered yes to either question above, Which of the following have you experienced? (check all that apply)

- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety Disorder
- ☐ Substance Use Disorder
- ☐ Eating Disorder
- ☐ Personality Disorder
- ☐ Psychotic Disorder
- ☐ Delirium
- ☐ Post-traumatic stress disorder (PTSD)
- ☐ Other ____

For each condition that apply to you, please specify:

	N/A	No change during COVID-19	Onset during COVID-19	Significant worsening during COVID-19	Moderate worsening during COVID-19	M imp C
Depression	○	○	○	○	○	
Bipolar Disorder	○	○	○	○	○	
Anxiety Disorder	○	○	○	○	○	
Substance Use Disorder	○	○	○	○	○	
Eating Disorder	○	○	○	○	○	

Personality Disorder	○	○	○	○	○
Psychotic Disorder	○	○	○	○	○
Delirium	○	○	○	○	○
Post-traumatic stress disorder (PTSD)	○	○	○	○	○
Other	○	○	○	○	○

Optionally describe how the conditions felt or affected you during COVID-19.

Depressive Symptoms

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More Than Half the Days	Nearly Every day
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○

Trouble falling/staying asleep, sleeping too much	○	○	○	○
Feeling tired or having little energy	○	○	○	○
	Not at all	Several Days	More Than Half the Days	Nearly Every day
Feeling bad about yourself or that you are a failure or have let yourself or your family down	○	○	○	○
Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	○	○	○	○
Thoughts that you would be better off dead or of hurting yourself in some way.	○	○	○	○
	Not at all	Several Days	More Than Half the Days	Nearly Every day

If you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

(Optional) If desired, please share more about your experience.

Anxiety Symptoms

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More Than Half the Days	Nearly Every day
Feeling nervous, anxious, or on edge	○	○	○	○
Not being able to stop or control worrying	○	○	○	○
Worrying too much about different things	○	○	○	○
Trouble relaxing	○	○	○	○

	Not at all	Several Days	More Than Half the Days	Nearly Every day
Being so restless that it is hard to sit still	○	○	○	○
Becoming easily annoyed or irritable	○	○	○	○
Feeling afraid as if something awful might happen	○	○	○	○

	Not at all	Several Days	More Than Half the Days	Nearly Every day

If you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ◯ Not difficult at all
- ◯ Somewhat difficult
- ◯ Very difficult
- ◯ Extremely difficult

(Optional) If desired, please share more about your experience.

Suicidal Thoughts

If you are having suicidal thoughts, these free helplines are available 24/7 to offer support:

US: 1-800-273-8255 (Crisis Text Line: text TALK to 741741)

UK: 116 123

Netherlands: 0800 0113

Canada: 833-456-4566

Find additional crisis lines for your country

At any time during the COVID-19 pandemic, have you ever:

- [ ] Wished you were dead or wished you could go to sleep and not wake up
- [ ] Had thoughts of killing yourself
- [ ] Had thoughts of harming yourself
- [ ] Done anything to harm yourself
- [ ] I did not have any suicidal thoughts
- [ ] Other

Psychiatric Medication

Have you been taking prescribed psychiatric medication while in recovery?

- ◯ Yes
- ◯ No

At any time during the COVID-19 pandemic, were there changes to your psychiatric medication?

- ◯ Yes, a dose adjustment was made to my prior medication
- ◯ Yes, new medications were prescribed to me
- ◯ No, I continued taking medication at the prior dose
- ◯ No, I have not required psychiatric medication

If you were prescribed NEW medications, what were they?

- [ ] Antidepressant (Not Bupropion)
- [ ] Wellbutrin (Bupropion)
- [ ] Benzodiazepine (anti-anxiety medication)
- [ ] Antipsychotic
- [ ] Z-drug for insomnia (e.g. zolpidem, zopiclone, zaleplon)
- [ ] Melatonin for insomnia
- [ ] Mood stabilizer (e.g. lithium, valproic acid, topiramate, etc)
- [ ] Stimulant
- [ ] Other

Have you been taking any of these medications, please indicate how they affected your condition. (Answer any that apply)

	Much better	Moderately better	Slightly better	About the same	Slightly worse	Moder wor
Antidepressant (SSRI/SNRI/Wellbutrin, etc.)	○	○	○	○	○	○
Benzodiazepine (anti-anxiety medication)	○	○	○	○	○	○
Antipsychotic	○	○	○	○	○	○
Z-drug for insomnia (e.g. zolpidem, zopiclone, zaleplon)	○	○	○	○	○	○

	Much better	Moderately better	Slightly better	About the same	Slightly worse	Moder wor
Melatonin for insomnia	○	○	○	○	○	○
Mood stabilizer (e.g. lithium, valproic acid, topiramate, etc)	○	○	○	○	○	○
Stimulant	○	○	○	○	○	○

Other	Much better	Moderately better	Slightly better	About the same	Slightly worse	Moder wor
	○	○	○	○	○	○

If you required psychiatric treatment during COVID-19, please check all that apply:

- ☐ I received treatment from my primary care provider / GP
- ☐ I received treatment from my prior mental health practitioner
- ☐ I received treatment from a new mental health practitioner
- ☐ I was unable to obtain the treatment that I needed

If you were not able to get psychiatric treatment, which of the following factored into the inability to receive care?

- ○ Cost
- ○ Access to a device compatible with tele-health
- ○ Preferred provider does not take my insurance
- ○ Preferred provider does not see patients via telehealth
- ○ Other

Coping

What wellbeing activities have you done/participated in to help you cope? (check all that apply)

- [ ] Online COVID-19 specific support groups/communities
- [ ] Online non-COVID-19 specific support groups/communities
- [ ] Therapy
- [ ] Yoga
- [ ] Aerobic exercise
- [ ] Meditation
- [ ] None of the above

If you have joined an online COVID-19 community, what is the effect of participation on your psychological wellbeing?

- ◯ Significantly improved my psychological wellbeing
- ◯ Moderately improved my psychological wellbeing
- ◯ Had no effect on my psychological wellbeing
- ◯ Moderately worsened my psychological wellbeing
- ◯ Significantly worsened my psychological wellbeing

Do you agree with this statement? "I was not believed by one or more of my physicians"

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Neither agree nor disagree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

(Optional) Describe how participation in online communities affect your wellbeing.

Being physically secluded from others has:

- ◯ Had a strong negative impact on my mental wellbeing
- ◯ Had a negative impact on my mental wellbeing
- ◯ Had no impact on my mental wellbeing
- ◯ Had a positive impact on my mental wellbeing
- ◯ Had a strong positive impact on my mental wellbeing
- ◯ I have not been physically secluded from others

(Optional) Rate the below 28 statements about methods of coping

	I haven't been doing this at all	A little bit	A medium amount	I've been doing this a lot
I've been turning to work or other activities to take my mind off things	◯	◯	◯	◯
I've been concentrating my efforts on doing something about the situation I'm in	◯	◯	◯	◯
I've been saying to myself "this isn't real"	◯	◯	◯	◯

I've been using alcohol or other drugs to make myself feel better	○	○	○	○
I've been getting emotional support from others	○	○	○	○
I've been giving up trying to deal with it	○	○	○	○
I've been taking action to try to make the situation better	○	○	○	○

	I haven't been doing this at all	A little bit	A medium amount	I've been doing this a lot
I've been refusing to believe that it has happened	○	○	○	○
I've been saying things to let my unpleasant feelings escape	○	○	○	○
I've been getting help and advice from other people	○	○	○	○
I've been trying to see it in a different light, to make it seem more positive	○	○	○	○
I've been criticizing myself	○	○	○	○
I've been trying to come up with a strategy about what to do	○	○	○	○
I've been getting comfort and understanding from someone	○	○	○	○

	I haven't been doing this at all	A little bit	A medium amount	I've been doing this a lot

I've been giving up the attempt to cope	○	○	○	○
I've been looking for something good in what is happening	○	○	○	○
I've been making jokes about it	○	○	○	○
I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping	○	○	○	○
I've been accepting the reality of the fact that it has happened	○	○	○	○
I've been expressing my negative feelings	○	○	○	○
I've been trying to find comfort in my religion or spiritual beliefs	○	○	○	○

	I haven't been doing this at all	A little bit	A medium amount	I've been doing this a lot
I've been trying to get advice or help from other people about what to do	○	○	○	○
I've been learning to live with it	○	○	○	○
I've been thinking hard about what steps to take	○	○	○	○
I've been blaming myself for things that happened	○	○	○	○
I've been praying or meditating	○	○	○	○
I've been making fun of the situation	○	○	○	○

	I haven't been doing this at all	A little bit	A medium amount	I've been doing this a lot

Anything else you'd like to share regarding coping.

Structural Support

How would you describe the support or lack of support from the following people during your illness?

	Harmful	Dismissive	Skeptical	Apathetic	Slightly concerne
Medical Providers	☐	☐	☐	☐	☐
Friends	☐	☐	☐	☐	☐
Spouse / Partner	☐	☐	☐	☐	☐
Family (not Spouse/Partner)	☐	☐	☐	☐	☐
Employer	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

(Optional) If you'd like, feel free to share your experience of the

support or lack of support of people during your illness.

While you have been ill, which of these scenarios matched your experience?

- [ ] I lived alone and felt well-equipped to take care of myself
- [ ] I lived alone and needed more help than I could get
- [ ] I lived with someone and they took care of me well
- [ ] I lived with someone and needed more help than I could get
- [ ] Other

If you were isolating, either in a space within the same house or in a different house, which of these scenarios matched your experienced best?

Please consider 'reunited' to mean you began living with others again, not just visiting/socializing with others.

- [ ] I was not isolating/I have been living with others throughout my illness.
- [ ] I reunited with others at some point during weeks 1-3 and they got infected (most likely from me)
- [ ] I reunited with others at some point during weeks 1-3 and they did not get infected
- [ ] I reunited with others at some point during weeks 4-6 and they got infected

- [ ] I reunited with others at some point during weeks 4-6 and they did not get infected
- [ ] I reunited with others at some point after week 6 and they got infected
- [ ] I reunited with others at some point after week 6 and they did not get infected
- [ ] I am still isolating/have not reunited with others
- [ ] N/A

Do you have any animal pets at home? *

- ◯ Yes
- ◯ No

If yes, please specify: *

- [ ] Cats
- [ ] Dogs
- [ ] Rodents
- [ ] Others

Regarding the medical care you have received during the COVID-19 pandemic: *

- ◯ I believe I received the appropriate amount of care
- ◯ I believe I received somewhat below the appropriate amount of care
- ◯ I believe I received significantly below the appropriate amount of care
- ◯ I did not require any medical care

Regarding financial status during the COVID-19 pandemic (choose all that apply): *

- [ ] I lost my job or have been unable to work if self-employed
- [ ] I have been unable to afford basic necessities like food and rent
- [ ] I have been under financial pressure but have been able to make ends meet
- [ ] I have not felt any financial pressures

(Optional) I believe my federal government and national public health institutions did the best they possibly could in handling the COVID-19 pandemic.

- ◯ Strongly agree
- ◯ Agree
- ◯ Somewhat agree
- ◯ Neither agree nor disagree
- ◯ Somewhat disagree
- ◯ Disagree
- ◯ Strongly disagree

If you have children, have your children been sick with COVID (or suspected COVID) for over three weeks?

- ◯ I don't have children.
- ◯ My children did not get sick.
- ◯ My children got sick but recovered in less than 3 weeks.
- ◯ One or more of my children have been sick for over 3 weeks, and one or more of my children have recovered before 3 weeks.

- ◯ All of my children have been sick for over 3 weeks.

Work

Were you employed pre-COVID?

- ◯ Yes, full-time
- ◯ Yes, part-time
- ◯ I was self-employed, full-time
- ◯ I was self-employed, part-time
- ◯ No

Did/do you need accommodation or reduced hours because of persistent issues/symptoms?

- ◯ Yes, I needed to reduce my hours (working in-person).
- ◯ Yes, I needed to reduce my hours (working remotely).
- ◯ Yes, I had to quit my job or was fired.
- ◯ No, I have been able to continue working as normal.
- ◯ Other, please describe

Other Medical Diagnostics

Have you received any medical diagnostic testing for your COVID-19

physical symptoms? (Scans, ultrasounds, ECGs)

- ◯ Yes
- ◯ No

Have you completed any of the following medical diagnostic testing? Note: If you have had any test done multiple times, please enter "Abnormal" if you received an abnormal result at any time.

	Not tested	Yes - normal	Yes - abnormal
MRI - brain	◯	◯	◯
MRI - chest	◯	◯	◯
CT scan - chest	◯	◯	◯
CT scan - brain	◯	◯	◯
CT scan - abdomen	◯	◯	◯

	Not tested	Yes - normal	Yes - abnormal
CT scan - pulmonary angiogram	◯	◯	◯
X-ray - chest	◯	◯	◯
Spinal tap (lumbar puncture)	◯	◯	◯
Ultrasound - leg	◯	◯	◯
Ultrasound (echo) - heart	◯	◯	◯

	Not tested	Yes - normal	Yes - abnormal
Ultrasound - abdomen	◯	◯	◯
ECG/EKG (heart)	◯	◯	◯
EEG (brain)	◯	◯	◯
EMG (muscle/nerves)	◯	◯	◯

Other			
	○	○	○
	Not tested	Yes - normal	Yes - abnormal

If the brain MRI, brain CT, or brain EEG were abnormal, please describe the results here.

If the chest MRI, chest CT, or chest X-ray were abnormal, please describe the results here.

If the spinal tap was abnormal, please describe the results here.

If the EMG was abnormal, please describe the results here.

If any of the other tests listed above were abnormal, please describe the results here.

If you had any abnormal tests that were not listed here, please describe the results here.

Diagnostics Blood Tests

Have you received diagnostic blood tests for your COVID-19 symptoms? (e.g. CBC)

- ◯ Yes
- ◯ No

What was the result of your blood tests for the following? If these were abnormal at one point but then resolved, please include the abnormal result.

	Not tested	Normal	Abnormal, high	Abnormal, low	Unsure/Can' find it
Creatinine (usually part of the basic metabolic panel)	○	○	○	○	○
Lymphocyte count (usually part of the CBC, complete blood count)	○	○	○	○	○
Eosinophils count (usually part of the CBC)	○	○	○	○	○
Eosinophils % (usually part of the CBC)	○	○	○	○	○
Hepatic Panel/Liver function test	○	○	○	○	○

	Not tested	Normal	Abnormal, high	Abnormal, low	Unsure/Can' find it
D-dimer	○	○	○	○	○
C-Reactive Protein	○	○	○	○	○
ESR (sedimentation rate)	○	○	○	○	○
Fibrinogen	○	○	○	○	○
Other	○	○	○	○	○

For any abnormal blood tests, please describe the result further

List any other abnormal blood tests. (Please put each abnormal test on a new line).

Have you been tested for these conditions since COVID?

	Not tested	Negative	Current/recent infection (since COVID)	Past infection
Epstein-Barr (mono)	○	○	○	○
Lyme disease	○	○	○	○
Cytomegalovirus (CMV)	○	○	○	○

Were you given any of these diagnoses for any of your symptoms? Please select all that apply.

- ☐ Guillain-Barre Syndrome
- ☐ Small fiber neuropathy
- ☐ Autonomic neuropathy
- ☐ Polyneuropathy
- ☐ Neuralgia (please include type of neuralgia in text box)
- ☐ Antiphospholipid Syndrome, viral induced or autoimmune
- ☐ Sarcoidosis

- [ ] Stroke (please include type of stroke in text box)
- [ ] Demyelinating lesions
- [ ] POTS
- [ ] Encephalopathy
- [ ] Encephalitis (please include type of encephalitis in text box)
- [ ] Mengingoencephalitis
- [ ] Meningitis
- [ ] Acute Disseminated Encephalomyelitis
- [ ] Acute myelitis
- [ ] Ophthalmoparesis
- [ ] Psychiatric Diagnosis
- [ ] Migraine
- [ ] Motor Peripheral or Cranial Neuropathies
- [ ] Posterior reversible encephalopathy syndrome
- [ ] Myasthenia
- [ ] Thrombotic microangiopathy
- [ ] Tapia Syndrome
- [ ] Epilepsy
- [ ] Traumatic Brain Injury (TBI) or TBI-like symptoms
- [ ] Myalgic Encephalomyelitis / Chronic Fatigue Syndrome (ME/CFS)
- [ ] Cranial nerve involvement
- [ ] Macular hole
- [ ] Costochondritis
- [ ] Blood clot
- [ ] Myocarditis

Please describe any other diagnosis you were given (if multiple, please put each diagnosis on a new line and press "enter" between each of them.)

Treatments

Have you tried any of the following treatments for your COVID19 symptoms, if yes, how helpful it was? (choose all that apply)

This includes Prescription or off-the-counter Medications, or Alternative Treatments.

	Did not try this	Slightly helpful	Significantly helpful	Not Helpful	Unsure
Non-medication treatment options Electrolytes	○	○	○	○	○
Pacing programs (regulating the amount of activity)	○	○	○	○	○
Adding salt to food and drinks	○	○	○	○	○
Compression garments (socks, leggings)	○	○	○	○	○
Acupuncture	○	○	○	○	○
Lymphatic massage	○	○	○	○	○

Anti-histamines H1 type Anti-histamines (diphenhydramine, acrivastine and cetirizine, like benadryl, zyrtec, claritin)	○	○	○	○	○
H2 type Anti-histamines (cimetidine, famotidine, like Pepcid)	○	○	○	○	○
Cannabis CBD/THC products	○	○	○	○	○
CBD-only products	○	○	○	○	○
Steroids Prednisone and Dexamethasone	○	○	○	○	○
Blood-thinners Baby aspirin (75-81mg)	○	○	○	○	○
Direct oral anticoagulants, Rivaroxaban (Xarelto)	○	○	○	○	○
Warfarin (Coumadin)	○	○	○	○	○
Anti-inflammatories Curcumin (tumeric)	○	○	○	○	○
Omega 3 / DHA / EPA (Fish oil)	○	○	○	○	○
Immune system treatments Intravenous gamma globulin	○	○	○	○	○
Convalescent plasma	○	○	○	○	○
Anti-viral medication Remsdesevir (Veklury)	○	○	○	○	○

Antibiotics Azithromycin	○	○	○	○	○
Malaria treatments Chloroquine	○	○	○	○	○
Hydroxychloroquine	○	○	○	○	○
Anti-oxidants Oxaloacetate	○	○	○	○	○
Over the counter painkillers Non-NSAIDs (Tylenol, Paracetamol)	○	○	○	○	○
NSAIDs (Ibuprofen, Naproxen, Adult aspirin (full dose))	○	○	○	○	○

Please describe any other treatments, medications/supplements, or anything else that significantly improved your symptoms. (Please put each on a new line by pressing 'enter' after each one).

Overall COVID Experience Text Write In

Optional: Please use this space to describe anything you particularly want others to know about the COVID experience, or that haven't been captured here. Please do not include any identifying information (such as name or location).

You have reached the end of the survey!

Please take a moment to review anything you may have missed. Once you are sure of your responses, *hit next to submit.*

Once submitted, you cannot go back to make modifications. Thank you for your energy and time!

To return to this survey later, ***bookmark the link that is in your browser****.*

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