Data collection sheet

* Required

1. Email *

2. Name of the data collector

3. Name of the institution of the data collector

4. Country of the data collector

Demographics and baseline characteristics

5. 1. What is your height?

6. 2. What is your weight?

7. 3. In which country do you currently reside?

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

_____

9. 5. What type of area do you live in?

Mark only one oval.

- Suburban
- Urban
- Rural

10. 6. What age group do you fall into?

Mark only one oval.

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

11. 7. Sex

Mark only one oval.

- Male
- Female

12. 8. If applicable, are you pregnant?

Mark only one oval.

- Yes
- No

13. 10. If applicable, do you have periods/a menstrual cycle?

Mark only one oval.

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

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

Mark only one oval.

- Asian, South Asian, southeast 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

15. 12. Is your household income from all sources?

Mark only one oval.

- Less than $10,000
- $10,000 to less than $20,000
- $20,000 to less than $25,000
- $25,000 to less than $35,000
- $35,000 to less than $50,000
- $50,000 to less than $75,000
- More than $75,000
- Don't know/Not sure

16. 13. What is your highest educational level achieved?

Mark only one oval.

- Less than high school
- Some high school
- High school degree or GED
- Partial college (at least one year) or specialized training
- Standard college degree
- Graduate professional degree including masters and doctorate

17. 14. Are you a healthcare professional?

Mark only one oval.

- Yes
- No

18. 15. What is your current work status? Select all that apply

Mark only one oval.

- On disability
- Student
- Homemaker
- Retired
- Unemployed
- Working part-time
- Working full-time

19. 16. Did you have COVID-19 infection? if no don't proceed

Mark only one oval.

- Yes
- No

COVID-19 Testing

20. What type of test was used to test you for COVID-19?

Mark only one oval.

- Nasal swab (PCR test)
- Spit test (PCR test)
- Swab or spit RAPID test (results within a couple of hours)
- Chest CT scan
- Clinical symptoms
- Don't know

21. What date were you tested for COVID-19? If you don't know the exact date, please choose your best approximation.

_____

Example: January 7, 2019

22. Did you consult with a physician(s) for your COVID-19 symptoms?

Mark only one oval.

- ◯ Yes
- ◯ No

23. Who did you consult for your COVID-19 symptoms?

Mark only one oval.

- ◯ 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
- ◯ I have not seen any physician

24. When did your symptoms begin?

Example: January 7, 2019

25. 2. Are you still experiencing symptoms?

Mark only one oval.

- Yes
- No

26. 3. How many days total did you experience symptoms?

27. 4.Lifestyle & Pre-existing Conditions: 1. Did you have any of these pre-existing conditions/diagnoses or did you experience any of the following pre-COVID-19?

Check all that apply.

- [ ] 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
- [ ] Chronic Obstructive Pulmonary Disease (COPD)
- [ ] Tuberculosis
- [ ] Eczema
- [ ] Viral skin conditions (cold sores, herpes, warts, molluscum)
- [ ] Dementia
- [ ] Seizures/epilepsy
- [ ] Migraine
- [ ] Amyotrophic lateral sclerosis
- [ ] Parkinson's disease
- [ ] Multiple Sclerosis
- [ ] Peripheral neuropathy
- [ ] Coronary Heart Disease
- [ ] Heart failure
- [ ] Hypertension (high blood pressure)
- [ ] Hypotension (low blood pressure)
- [ ] History of blood 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
- [ ] Other: _____

28. 6. Did any of your pre-existing conditions change during your COVID19 symptoms?

Mark only one oval.

- ◯ Yes, they got worse.
- ◯ Yes, they got better.
- ◯ No, they stayed the same.
- ◯ N/A (I did not have any pre-existing condition)

29. 7. In the month before becoming ill if you were sick, or in the previous month if you were not, were you a regular, occasional, or never smoker?

Mark only one oval.

- Never
- Occasionally
- Regularly

Hospitalization & Treatments

30. 1. Were you hospitalized?

Mark only one oval.

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

31. 2. If yes: how long were you hospitalized? [Number of days]

_____

32. 3. Did you receive oxygen support in the hospital?

Mark only one oval.

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

33. Have you tried any of the following treatments for your COVID19 symptoms, if yes, how helpful it was? This includes Prescription or off-the-counter Medications, or Alternative Treatments.

Check all that apply.

- [ ] Anti-histamines
- [ ] H1 type Antihistamines
- [ ] (Diphenhydramine, acrivastine, and cetirizine, like Benadryl, Zyrtec, Claritin)
- [ ] H2 type Antihistamines (cimetidine,famotidine, like Pepcid)
- [ ] Products Containing Cannabis or Cannabis-derived Compounds, Including delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD)
- [ ] Steroids(Prednisone and Dexamethasone etc)
- [ ] Apixaban (Eliquis)
- [ ] Dabigatran (Pradaxa)
- [ ] Dalteparin (Fragmin)
- [ ] Edoxaban (Savaysa)
- [ ] Enoxaparin (Lovenox)
- [ ] Fondaparinux (Arixtra)
- [ ] Heparin (Innohep)
- [ ] Rivaroxaban (Xarelto)
- [ ] Warfarin (Coumadin, Jantoven)
- [ ] Aspirin
- [ ] Cilostazol
- [ ] Clopidogrel (Plavix)
- [ ] Dipyridamole (Persantine)
- [ ] Eptifibatide (Integrilin)
- [ ] Prasugrel (Effient)
- [ ] Ticagrelor (Brilinta)
- [ ] Tirofiban (Aggrastat)
- [ ] Vorapaxar (Zontivity)
- [ ] Remsdesevir
- [ ] Veklury (an antiviral medicine used to treat coronavirus disease
- [ ] Antibiotics
- [ ] Azithromycin
- [ ] Malaria treatments
- [ ] Chloroquine
- [ ] Hydroxychloroquine
- [ ] Anti-oxidants
- [ ] Oxaloacetate
- [ ] Over the counter painkillers
- [ ] Non-NSAIDs
- [ ] (Tylenol, Paracetamol)
- [ ] NSAIDs (Ibuprofen,Naproxen, Adult aspirin (full dose))

- [ ] Direct oral anticoagulants
- [ ] Rivaroxaban (Xarelto)
- [ ] Warfarin (Coumadin)
- [ ] Anti-inflammatories
- [ ] Curcumin (tumeric)
- [ ] Omega 3 / DHA / EPA (Fish oil)
- [ ] Intravenous gamma globulin
- [ ] Convalescent plasma
- [ ] None
- [ ] Others (specify)
- [ ] Other: _____

34. Have you got the Covid-19 vaccine?

Mark only one oval.

- ◯ Yes
- ◯ No

35. Type of the vaccine

Mark only one oval.

- ◯ Comirnaty (BNT162b2) (Pfizer, BioNTech; Fosun Pharma)
- ◯ Moderna COVID-19 Vaccine (mRNA-1273); also called Spikevax (Moderna, BARDA, NIAID)
- ◯ COVID-19 Vaccine AstraZeneca (AZD1222); also known as Vaxzevria and Covishield (BARDA, OWS)
- ◯ Sputnik V (Gamaleya Research Institute, Acellena Contract Drug Research and Development, Russia)
- ◯ Sputnik Light (Gamaleya Research Institute, Acellena Contract Drug Research and Development, Russia)
- ◯ COVID-19 Vaccine Janssen (JNJ-78436735; Ad26.COV2.S) (Janssen Vaccines (Johnson & Johnson)
- ◯ CoronaVac (Sinovac)
- ◯ BBIBP-CorV (Beijing Institute of Biological Products; China National Pharmaceutical Group (Sinopharm))
- ◯ EpiVacCorona (Federal Budgetary Research Institution State Research Center of Virology and Biotechnology)
- ◯ Convidicea (PakVac, Ad5-nCoV) (CanSino Biologics)

36. How many shots have you got?

_____

37. When you get the vaccine

_____

Example: January 7, 2019

38. Have you got infected with COVID-19 after vaccination?

Mark only one oval.

- ◯ Yes
- ◯ No

39. Have you always had persistent or recurring fatigue/energy problems, even back to your earliest memories as a child? (By persistent or recurring, we mean that the fatigue/energy problems are usually ongoing and constant, but sometimes there are good periods and bad periods.)

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Not having a problem with fatigue/energy

Chronic Fatigue experience

40. Since your fatigue/energy related illness began, do your headaches either happen more often, feel worse or more severe, or are they in a different place or spot?

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Not having a problem with fatigue/energy

41. How long ago did your problem with fatigue/energy begin?

Mark only one oval.

- ◯ Less than 6 months
- ◯ 6-12 months
- ◯ 1-2 years
- ◯ Longer than 2 years
- ◯ Had problem with fatigue/energy since childhood or adolescence
- ◯ Not having a problem with fatigue/energy

42. Have you been diagnosed with chronic fatigue syndrome or Myalgic Encephalomyelitis?

Mark only one oval.

- ◯ Yes
- ◯ No

43. In what year were you diagnosed?

_____

Example: January 7, 2019

44. Was this diagnosis?

Mark only one oval.

- ◯ After COVID-19 infection
- ◯ After COVID-19 vaccine
- ◯ Unrelated to COVID-19

45. Who diagnosed you with chronic fatigue syndrome or Myalgic Encephalomyelitis?

Mark only one oval.

- ◯ Medical Doctor
- ◯ Alternative Practitioner
- ◯ Self-Diagnosed

46. Do you currently have a diagnosis of chronic fatigue syndrome or Myalgic Encephalomyelitis?

Mark only one oval.

- Yes
- No

47. Have any of your family members been diagnosed with chronic fatigue syndrome or Myalgic Encephalomyelitis? If yes, please list their relation to you and current age:

Mark only one oval.

- Yes
- No

DePaul Symptom Questionnaire (DSQ-2)

48. 1. Fatigue/extreme tiredness

Mark only one oval per row.

	1	2	3	4
Frequency				
Severity				

49. 2. Next day soreness or fatigue after non-strenuous, everyday activities

Mark only one oval per row.

	1	2	3	4
Frequency				
Severity				

50. 3. Minimum exercise makes you physically tired

Mark only one oval per row.

	1	2	3	4
Frequency				
Severity				

51. 4. Feeling unrefreshed after you wake up in the morning

Mark only one oval per row.

	1	2	3	4
Frequency				
Severity				

52. 5. Pain or aching in your muscles

Mark only one oval per row.

	1	2	3	4
Frequency				
Severity				

53. 6. Bloating

Mark only one oval per row.

	1	2	3	4
Frequency				
Severity				

54. 7. Problems remembering things

Mark only one oval per row.

	1	2	3	4
Frequency				
Severity				

55. 8. Difficulty paying attention for a long period of time

Mark only one oval per row.

	1	2	3	4
Frequency				
Severity				

56. 9. Irritable bowel problems

Mark only one oval per row.

	1	2	3	4
Frequency				
Severity				

57. 10. Feeling unsteady on your feet, like you might fall

Mark only one oval per row.

	1	2	3	4
Frequency				
Severity				

58. 11. Cold limbs (e.g. arms, legs, hands)

Mark only one oval per row.

	1	2	3	4
Frequency				
Severity				

59. 12. Feeling hot or cold for no reason

Mark only one oval per row.

	1	2	3	4
Frequency				
Severity				

60. 13. Flu-like symptoms

Mark only one oval per row.

	1	2	3	4
Frequency				
Severity				

61. 14. Some smells, foods, medications, or chemicals make you feel sick

Mark only one oval per row.

	1	2	3	4
Frequency				
Severity				

This survey asks for your views about how you feel and how well you are able to do your usual activities. please give the best answer you can.

62. 15. In general, would you say your health is: (Please circle one)

Mark only one oval.

- Excellent 1
- Very good 2
- Good 3
- Fair 4
- Poor 5

63. 16. Compared to one year ago, how would you rate your health in general now? (Please circle one)

Mark only one oval.

- Much better than one year ago 1
- Somewhat better now than one year ago 2
- About the same as one year ago 3
- Somewhat worse now than one year ago 4
- Much worse now than one year ago 5
- Option 6

64. 17. Vigorous activities: running, lifting heavy objects, participating in strenuous sports

Mark only one oval.

- Yes, Limited A Lot
- Yes, Limited A Little
- No, Not Limited At All

65. 18. Moderate activities: moving a table, pushing a vacuum cleaner, bowling, playing golf

Mark only one oval.

- Yes, Limited A Lot
- Yes, Limited A Little
- No, Not Limited At All

66. 19. Lifting or carrying groceries

Mark only one oval.

- Yes, Limited A Lot
- Yes, Limited A Little
- No, Not Limited At All

67. 20. Climbing several flights of stairs

Mark only one oval.

- Yes, Limited A Lot
- Yes, Limited A Little
- No, Not Limited At All

68. 21. Climbing one flight of stairs

Mark only one oval.

- Yes, Limited A Lot
- Yes, Limited A Little
- No, Not Limited At All

69. 22. Bending, kneeling or stooping

Mark only one oval.

- Yes, Limited A Lot
- Yes, Limited A Little
- No, Not Limited At All

70. 23. Walking more than a mile

Mark only one oval.

- Yes, Limited A Lot
- Yes, Limited A Little
- No, Not Limited At All

71. 24. Walking several blocks

Mark only one oval.

- Yes, Limited A Lot
- Yes, Limited A Little
- No, Not Limited At All

72. 25. Walking one block

Mark only one oval.

- Yes, Limited A Lot
- Yes, Limited A Little
- No, Not Limited At All

73. 26. Bathing or dressing yourself

Mark only one oval.

- Yes, Limited A Lot
- Yes, Limited A Little
- No, Not Limited At All

During the past 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?

74. 27. Cut down on the amount of time you spent on work or other activities

Mark only one oval.

- Yes
- No

75. 28. Accomplished less than you would like

Mark only one oval.

- Yes
- No

76. 29. Were limited in the kind of work or other activities

Mark only one oval.

- Yes
- No

77. 30. Had difficulty performing the work or other activities (For example, it took extra effort)

Mark only one oval.

- Yes
- No

78. 31. Cut down the amount of time you spent on work or other activities

Mark only one oval.

- Yes
- No

79. 32. Accomplished less than you would like

Mark only one oval.

- Yes
- No

80. 33. Didn't do work or other activities as carefully as usual

Mark only one oval.

- Yes
- No

81. 34. to what extent has your physical health or emotional problems interfered with your normal social activities with family, neighbors, or groups During the past 4 weeks,? (Please circle one)

Mark only one oval.

- ◯ Not at all 1
- ◯ Slightly 2
- ◯ Moderately 3
- ◯ Quite a bit 4
- ◯ Extremely 5

82. 35. How much bodily pain have you had during the past 4 weeks? None .

Mark only one oval.

- ◯ None 1
- ◯ Very mild 2
- ◯ Mild 3
- ◯ Moderate 4
- ◯ Severe 5
- ◯ Very Severe 6

83. 36. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Mark only one oval.

- ◯ Not at all 1
- ◯ Slightly 2
- ◯ Moderately 3
- ◯ Quite a bit 4
- ◯ Extremely 5

84. 37. Did you feel full of pep?

Mark only one oval.

- All of the Time
- Most of the Time
- A Good Bit of the Time
- Some of the Time
- A Little of the Time
- None of the Time

85. 38. Have you been a nervous person?

Mark only one oval.

- All of the Time
- Most of the Time
- A Good Bit of the Time
- Some of the Time
- A Little of the Time
- None of the Time

86. 39. Have you felt so down in the dumps that nothing could cheer you up?

Mark only one oval.

- All of the Time
- Most of the Time
- A Good Bit of the Time
- Some of the Time
- A Little of the Time
- None of the Time

87. 40. Have you felt calm and peaceful?

Mark only one oval.

- All of the Time
- Most of the Time
- A Good Bit of the Time
- Some of the Time
- A Little of the Time
- None of the Time

88. 41. Did you have a lot of energy?

Mark only one oval.

- All of the Time
- Most of the Time
- A Good Bit of the Time
- Some of the Time
- A Little of the Time
- None of the Time

89. 42. Have you felt down-hearted and blue?

Mark only one oval.

- All of the Time
- Most of the Time
- A Good Bit of the Time
- Some of the Time
- A Little of the Time
- None of the Time

90. 43. Did you feel worn out?

Mark only one oval.

- All of the Time
- Most of the Time
- A Good Bit of the Time
- Some of the Time
- A Little of the Time
- None of the Time

91. 44. Have you been a happy person?

Mark only one oval.

- All of the Time
- Most of the Time
- A Good Bit of the Time
- Some of the Time
- A Little of the Time
- None of the Time

92. 45. Did you feel tired?

Mark only one oval.

- All of the Time
- Most of the Time
- A Good Bit of the Time
- Some of the Time
- A Little of the Time
- None of the Time

93. 46. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

Mark only one oval.

- All of the time 1
- Most of the time 2
- Some of the time 3
- A little of the time 4
- None of the time 5

94. 47. I seem to get sick a little easier than other people

Mark only one oval.

- Definitely True
- Mostly True
- Don't Know
- Mostly False
- Definitely False

95. 48. I am as healthy as anybody I know

Mark only one oval.

- Definitely True
- Mostly True
- Don't Know
- Mostly False
- Definitely False

96. 49. I expect my health to get worse

Mark only one oval.

- Definitely True
- Mostly True
- Don't Know
- Mostly False
- Definitely False

97. 50. My health is excellent

Mark only one oval.

- Definitely True
- Mostly True
- Don't Know
- Mostly False
- Definitely False

Patient Health Questionnaire (PHQ-9)

98. 1) Little interest or pleasure in doing things?

Mark only one oval.

- Not at all
- Several days
- More than half the days
- Nearly every day

99. 2) Feeling down, depressed, or hopeless?

Mark only one oval.

- Not at all
- Several days
- More than half the days
- Nearly every day

100. 3) Trouble falling or staying asleep, or sleeping too much?

Mark only one oval.

- Not at all
- Several days
- More than half the days
- Nearly every day

101. 4) Feeling tired or having little energy?

Mark only one oval.

- Not at all
- Several days
- More than half the days
- Nearly every day

102. 5) Poor appetite or overeating?

Mark only one oval.

- Not at all
- Several days
- More than half the days
- Nearly every day

103. 6) Feeling bad about yourself - or that you are a failure or have let yourself or your family down?

Mark only one oval.

- Not at all
- Several days
- More than half the days
- Nearly every day

104. 7) Trouble concentrating on things, such as reading the newspaper or watching television?

Mark only one oval.

- Not at all
- Several days
- More than half the days
- Nearly every day

105. 8) 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?

Mark only one oval.

- Not at all
- Several days
- More than half the days
- Nearly every day

106. 9) 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

Mark only one oval.

- Not at all
- Several days
- More than half the days
- Nearly every day

Other symptoms related to COVID

107. 1. Were you given any of these diagnoses for any of your symptoms?

Check all that apply.

- [ ] Guillain-Barre Syndrome
- [ ] Small fiber neuropathy Autonomic neuropathy
- [ ] Polyneuropathy
- [ ] Neuralgia (please include the type of neuralgia in the text box)
- [ ] Antiphospholipid Syndrome, viral-induced or autoimmune
- [ ] Sarcoidosis
- [ ] Stroke (please include the type of stroke in the text box)
- [ ] Demyelinating lesions
- [ ] POTS
- [ ] Encephalopathy
- [ ] Encephalitis (please include the type of encephalitis in the text box)
- [ ] Meningoencephalitis
- [ ] Meningitis
- [ ] Acute Disseminated Encephalomyelitis
- [ ] Acute myelitis
- [ ] Ophthalmo-paresis
- [ ] 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
- [ ] Other: _____

108. Was this diagnosis?

Mark only one oval.

- ◯ Before COVID-19 infection
- ◯ After COVID-19 infection
- ◯ After COVID-19 vaccine
- ◯ Unrelated to COVID

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

Mark only one oval.

- ◯ Yes
- ◯ No

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

Check all that apply.

- ☐ 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 shoelaces, washing your hands) None of the above
- ☐ Other: _____

111. 4. 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? *

Mark only one oval.

- ◯ Yes
- ◯ No

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

Check all that apply.

- ☐ 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: _____

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

Check all that apply.

- [ ] 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: _____

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

Mark only one oval.

- ◯ Yes
- ◯ No

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

Check all that apply.

- [ ] Difficulty finding the right words while speaking/writing
- [ ] Difficulty communicating verbally
- [ ] Difficulty 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
- [ ] Other: _____

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

Mark only one oval.

- ◯ Yes
- ◯ No

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

Check all that apply.

- [ ] Headaches, at the base of the skull
- [ ] Headaches, in the temples
- [ ] Headaches, behind the eyes
- [ ] Headaches, diffuse (entire brain)
- [ ] Headaches/pain after mental exertion
- [ ] Sensation of brain warmth/"on fire"
- [ ] Sensation of brain pressure
- [ ] Migraines
- [ ] None of the above
- [ ] Other: _____

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

Mark only one oval.

- ◯ Yes
- ◯ No

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

Check all that apply.

- ☐ 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
- ☐ Other: _____

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

Mark only one oval.

- ◯ Yes
- ◯ No

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

Mark only one oval.

- ◯ Yes
- ◯ No

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

Check all that apply.

- ☐ 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: _____

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

Check all that apply.

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

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

Mark only one oval.

- ◯ Yes
- ◯ No

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

Check all that apply.

- ☐ Visual (seeing) Hallucinations
- ☐ Auditory (hearing) Hallucinations
- ☐ Tactile (touch) Hallucinations
- ☐ Hallucinations
- ☐ Other: _____

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

Check all that apply.

- ☐ 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:
- ☐ None of the above

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

Mark only one oval.

- ◯ Yes
- ◯ No

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

Check all that apply.

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

129. 23. Which of the following symptoms have you experienced? *

Check all that apply.

- ☐ 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)
- ☐ None of the above

130. 24. Generic Issues

Check all that apply.

- [ ] 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)

131. 25. Have you experienced any Gastrointestinal Issues since the start of your COVID-19 illness? *

Mark only one oval.

- ◯ Yes
- ◯ No

132. 26. Which of the following Gastrointestinal Issues have you experienced since the start of your COVID-19 illness? *

Check all that apply.

- [ ] None of the below gastrointestinal symptoms apply to me
- [ ] Constipation
- [ ] Diarrhea
- [ ] Vomiting
- [ ] Nausea
- [ ] Loss of Appetite
- [ ] Abdominal pain
- [ ] Lower
- [ ] Esophagus
- [ ] Burning /
- [ ] gastroesophageal reflux / acid reflux

133. 27. Have you experienced any Respiratory and Sinus Symptoms since the start of your COVID-19 illness? *

Mark only one oval.

- ◯ Yes
- ◯ No

134. 28. Which of the following Respiratory and Sinus Symptoms have you experienced since the start of your COVID-19 illness? *

Check all that apply.

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

135. 29. Have you experienced any Skin and Allergy Symptoms since the start of your COVID-19 illness? *

Mark only one oval.

- ◯ Yes
- ◯ No

136. 30. Which of the following Skin and Allergy Symptoms have you experienced since the start of your COVID-19 illness?

Check all that apply.

- [ ] None of the below skin and allergy symptoms apply to me
- [ ] Skin and Allergy Symptoms
- [ ] 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: _____

137. 31. Have you experienced any Muscle and Joint issues since the start of your COVID-19 illness? *

Mark only one oval.

- ◯ Yes
- ◯ No

138. 32. Which of the following Muscle and Joint issues have you experienced since the start of your COVID-19 illness?

Check all that apply.

- [ ] Muscle and Joint issues
- [ ] Muscle spasms
- [ ] Muscle aches
- [ ] Joint pain
- [ ] Bone ache or burning
- [ ] None of the above

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

Check all that apply.

- [ ] (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

140. 34. Have you experienced any Ear and Hearing since the start of your COVID-19 illness? *

Mark only one oval.

- ◯ Yes
- ◯ No

141. 35. Which of the following Ear and Hearing have you experienced since the start of your COVID-19 illness?

Check all that apply.

- [ ] 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

142. 36. Have you experienced any Eye and Vision since the start of your COVID-19 illness? *

Mark only one oval.

- ◯ Yes
- ◯ No

143. 37. Which of the following Eye and Vision have you experienced since the start of your COVID-19 illness?

Check all that apply.

- ☐ 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
- ☐ None of the above
- ☐ Other: _____

144. 38. Have you experienced any Reproductive and Urinary Symptoms since the start of your COVID-19 illness? *

Mark only one oval.

- ◯ Yes
- ◯ No

145. 39. Which of the following Reproductive and Urinary Symptoms have you experienced since the start of your COVID-19 illness?

Check all that apply.

- [ ] 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,
- [ ] Bladder control

146. 40. Have you experienced any Gastrointestinal issues since the start of your COVID-19 illness? *

Mark only one oval.

- ◯ Yes
- ◯ No

147. 41. Which of the following Gastrointestinal issues have you experienced since the start of your COVID-19 illness? Urinary

Check all that apply.

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

148. 42. Have you experienced any Skin and Allergy since the start of your COVID-19 illness? *

Mark only one oval.

- ◯ Yes
- ◯ No

149. 43. Which of the following Skin and Allergy have you experienced since the start of your COVID-19 illness? Urinary

Check all that apply.

- ☐ 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

150. 44. General Functioning In general, would you say your health BEFORE the onset of COVID was: *

Mark only one oval.

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

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

Mark only one oval.

- ◯ Yes
- ◯ No

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

Mark only one oval.

- ◯ Yes
- ◯ No

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

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

154. 49. Have you ever experienced vertigo/dizziness before COVID-19 diagnosis?

Mark only one oval.

- ◯ Yes
- ◯ No

155. 51. Have you started experiencing dizziness or vertigo after diagnosis of COVID-19?

Mark only one oval.

- Yes
- No

156. 52. If YES, please describe the characteristics of your symptoms

Check all that apply.

- violent vertigo attacks
- chronic dizziness
- instability

157. 53. Indicate the severity of your vertigo/dizziness (0–10)

Mark only one oval.

1	2	3	4	5	6	7	8	9	10

158. 54. Have you ever experienced tinnitus before COVID-19 diagnosis?

Mark only one oval.

- Yes
- No

159. 55. Have you started experiencing tinnitus after diagnosis of COVID-19?

Mark only one oval.

- Yes
- No

160. 56. If yes, please specify the characteristics of your tinnitus

Mark only one oval.

- occasional
- continuous floating
- persistent
- pulsatile
- continuous

161. 57. Do you suffer from migraine? (yes/no)

Mark only one oval.

- Yes
- No