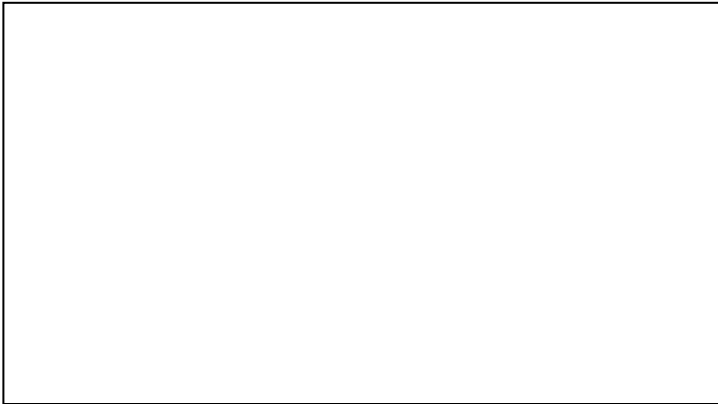


**POST COVID-19 RECOVERY CLINIC
BASELINE QUESTIONNAIRE**



Questionnaire completed on: (dd/mmm/yyyy) _____

Clinic visit date: (dd/mmm/yyyy) _____ (if different from completion date)

1. PATIENT DEMOGRAPHICS

Name: _____
Last First Cell phone
 Date of Birth: (dd/mmm/yyyy) _____/_____/_____

What is your living situation? Please check ONE answer for each question.

I live:

- Alone
- With other(s)

: Families:

- spouse
- children
- parents
-

Are you employed? Yes No

If Yes, what is your occupation: _____

Industry of employment: _____

- Do you work: Full time (regular hours)
 Part time (greater than 50% of regular hours)
 Part time (less than 50% of regular hours)
 Unable to work following COVID-19 illness

What is your ethnicity?

- White (Caucasian) Hispanic
- Black (e.g. African, Somali)
- Asian: (specify) _____
- Other: (specify) _____

2. SMOKING HISTORY

Have you ever smoked cigarettes? Yes No

If Yes: Do you smoke cigarettes now (at least 1 per day for the past year)? Yes No

What year did you start smoking? _____

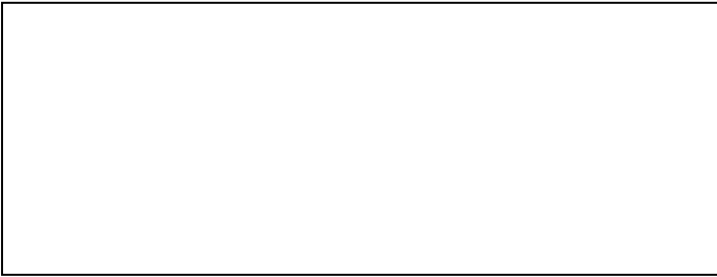
What year did you stop smoking? _____ (if you are still smoking mark N/A) N/A

On average, how many cigarettes do/did you smoke per day? _____

Did you use vaping products in the 3 months before you had COVID-19? Yes No

Did you smoke marijuana in the 3 months before you had COVID-19? Yes No

**POST-COVID-19 RECOVERY CLINIC
BASELINE QUESTIONNAIRE**



2. COVID-19 HISTORY

Which of the following symptoms were new or worse than usual when you had COVID-19?	New or worse symptoms just before or during admission to hospital	Symptoms still present
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Chest congestion (phlegm production)	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Loss of taste and smell	<input type="checkbox"/>	<input type="checkbox"/>
Hoarse voice/change in voice	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Muscle or joint aches	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Discolouration of fingers or toes	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>

When did your first symptom(s) start? (dd/mmm/yyyy) _____ / _____ / _____

Do your symptoms fluctuate in severity? Yes No

Are your symptoms brought on by: Physical exertion Cognitive tasks Emotional events

Do your symptoms improve with rest? Yes No

3. MEDICAL STATUS

**Please answer “Yes” or “No” for all the items below as they apply to you now.
If you are unsure, please select the option that feels most appropriate to you.**

Long term disabilities or handicaps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Restriction of activity due to poor health	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Help for preparing meals	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Help for shopping for necessities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Help for housework	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Help for heavy household chores	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Help for personal care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Help for moving inside house	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Food allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**POST COVID-19 RECOVERY CLINIC
BASELINE QUESTIONNAIRE**

3. MEDICAL STATUS (continued)

Arthritis or rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back problems other than arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Migraine headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic bronchitis or emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach or intestinal ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Effects of a stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Problems with urinary incontinence	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dementia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other chronic conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vision problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Walking difficulty	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dexterity problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cognitive problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Body pain that prevents activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Speech problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty carrying light weight	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unhappy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Less activity at home, work, or school	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Feeling hopeless	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lost weight	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Self-reported poor health	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty with problem solving	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Always feeling tired	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**POST-COVID-19 RECOVERY CLINIC
BASELINE QUESTIONNAIRE**

4. COUGH

Do you have a cough?

This includes any chronic cough, even if there is no phlegm or mucus. Do not include clearing your throat.

No Yes – If Yes, what date did the cough start? (dd/mmm/yyyy) _____/_____/_____

Place a vertical mark across the line below to indicate the severity of your cough:

No cough | score 1 to 10 | **Worst cough imaginable**

Do you cough up phlegm or mucus? Yes No

5. SHORTNESS OF BREATH

For each activity listed below, please rate your breathlessness on a scale of 0 to 5, where 0 is not at all breathless and 5 is maximally breathless or too breathless to do the activity. If the activity is one which you do not perform, please give your best estimate of breathlessness. Your responses should be for an average day during the past week.

PLEASE RESPOND TO ALL ITEMS.

How short of breath do you get while:	Maximally breathless or too breathless to do the activity					
	0	1	2	3	4	5
At rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking on level surface at your own pace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking on level surface with others your age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking up a hill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking up stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
While eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing up from a chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brushing your teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shaving and/or brushing hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Showering/bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picking up and straightening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing dishes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweeping/vacuuming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making the bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washing the car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mowing the lawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watering the lawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How much do the things below limit you in your daily life?

Does not limit me

Completely limits me

Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear of hurting myself by overexerting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear of shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**POST COVID-19 RECOVERY CLINIC
BASELINE QUESTIONNAIRE**

6. QUALITY OF LIFE

Under each heading, tick ONE box that best describes your health TODAY.

MOBILITY

- I have no problems walking about
- I have slight problems walking about
- I have moderate problems walking about
- I have severe problems walking about
- I am unable to walk about

SELF-CARE

- I have no problems washing or dressing myself
- I have slight problems washing or dressing myself
- I have moderate problems washing or dressing myself
- I have severe problems washing or dressing myself
- I am unable to wash or dress myself

USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)

- I have no problems doing my usual activities
- I have slight problems doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

PAIN / DISCOMFORT

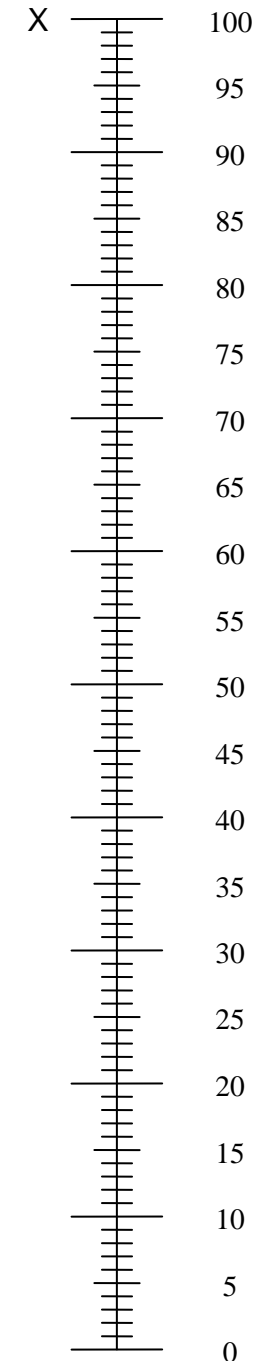
- I have no pain or discomfort
- I have slight pain or discomfort
- I have moderate pain or discomfort
- I have severe pain or discomfort
- I have extreme pain or discomfort

ANXIETY / DEPRESSION

- I am not anxious or depressed
- I am slightly anxious or depressed
- I am moderately anxious or depressed
- I am severely anxious or depressed
- I am extremely anxious or depressed

To move the X on this scale:
Place your cursor in front of the "X" and click return on your keyboard until the X is in position next to the number you want to record.

The best health you can imagine



We would like to know how good or bad you feel your health is TODAY.

The scale to the right, is numbered from 0 to 100.

100 means the BEST health you can imagine.

0 means the WORST health you can imagine.

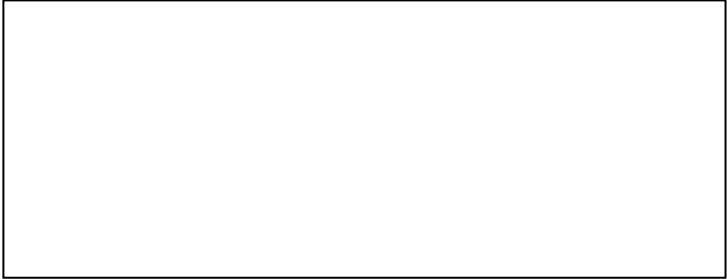
Mark an X on the scale to indicate how you feel your health is TODAY.

Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY =

The worst health you can imagine

**POST-COVID-19 RECOVERY CLINIC
BASELINE QUESTIONNAIRE**

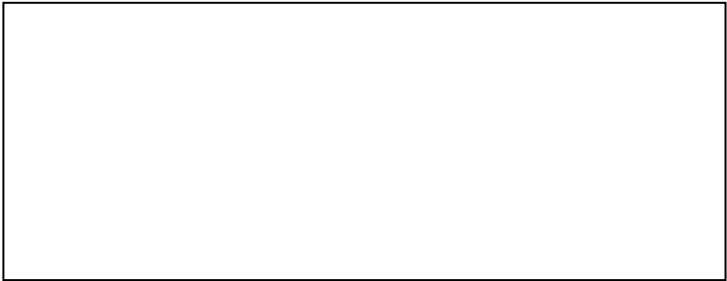


7. NEUROLOGY SCREEN			
Have you experienced any of the following symptoms?	Symptom present <u>before</u> COVID illness	Symptom new or much worse <u>during</u> acute COVID illness	Symptom experienced at <u>present</u>
Weakness in face, arms, or legs (or all)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/loss of feeling in face, arms, or legs (or all)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shooting, stabbing or burning pains, muscle aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle stiffness or slowness of movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache, neck stiffness or eye pain with eye movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of the ability to speak or understand what others are saying, slurred speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory problems, searching for words, slowed thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of consciousness, reduced awareness, coma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremor (shaking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle twitches or involuntary movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with walking or balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision loss in one or both eyes, double vision, blurry vision, trouble focusing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sense of smell or taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus (ringing in your ears)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel or bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness, spinning, unsteadiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble with sleep, including falling/staying asleep, poor quality sleep, acting out dreams (talking, kicking, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**POST COVID-19 RECOVERY CLINIC
BASELINE QUESTIONNAIRE**

8. PSYCHIATRY SCREEN				
Please select an answer for each of the following questions based on what you have been feeling and experiencing during the last 2 weeks.			Clinician Use Only	
			Item Score	Screen Score
How often have you been feeling nervous, anxious or on edge?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half of the days <input type="checkbox"/> Nearly every day			<input type="text"/>
How often have you not been able to stop or control your worrying?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half of the days <input type="checkbox"/> Nearly every day			<input type="text"/>
How often have you experienced little interest or pleasure in doing things?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half of the days <input type="checkbox"/> Nearly every day			<input type="text"/>
How often have you been feeling down, depressed or hopeless?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half of the days <input type="checkbox"/> Nearly every day			<input type="text"/>
Have you ever felt that you ought to cut down on your drinking or drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="text"/>
Have people annoyed you by criticizing your drinking or drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever felt bad or guilty about your drinking or drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you had frequent unwanted thoughts that seem difficult to control?	<input type="checkbox"/> Yes <input type="checkbox"/> Maybe/Not sure <input type="checkbox"/> No			<input type="text"/>
Have you felt an urge that was difficult to control to repeat actions (e.g. washing, checking)?	<input type="checkbox"/> Yes <input type="checkbox"/> Maybe/Not sure <input type="checkbox"/> No			<input type="text"/>
Have you felt very happy or irritable for time periods lasting at least 2 days?	<input type="checkbox"/> Yes <input type="checkbox"/> Maybe/Not sure <input type="checkbox"/> No			<input type="text"/>
Have you felt full of energy for time periods lasting at least 2 days?	<input type="checkbox"/> Yes <input type="checkbox"/> Maybe/Not sure <input type="checkbox"/> No			<input type="text"/>
Have you thought that other people are plotting against you or are trying to hurt you?	<input type="checkbox"/> Yes <input type="checkbox"/> Maybe/Not sure <input type="checkbox"/> No			<input type="text"/>
Have you noticed any unusual experiences – like hearing or seeing things other people couldn't or when other people are not present?	<input type="checkbox"/> Yes <input type="checkbox"/> Maybe/Not sure <input type="checkbox"/> No			

**POST-COVID-19 RECOVERY CLINIC
BASELINE QUESTIONNAIRE**



9. TRAUMATIC EVENTS		
The following questions refer specifically to ANY TRAUMATIC EXPERIENCES YOU MAY HAVE EVER HAD , including your hospital stay for COVID-19 disease or any other traumatic event.	Clinician Use only	
	Item Score	Screen Score
During the last 2 weeks have you:		
Had nightmares about these events or thought about these events when you did not want to? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>
Tried hard not to think about these events or went out of your way to avoid situations that reminded you of these events? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Been constantly on guard, watchful, or easily startled? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Felt numb or detached from people, activities, or your surroundings? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Felt guilty or unable to stop blaming yourself or others for these events or any problems the event may have caused? <input type="checkbox"/> Yes <input type="checkbox"/> No		

10. FATIGUE SEVERITY SCALE							
Choose a number from 1 to 7 that indicates how much you agree with the following statements. Please base your answer on how you have been feeling on average over the past week. 1 = strongly disagree 4 = neither agree nor disagree 7 = strongly agree.							
During the past week, I have found that:	1	2	3	4	5	6	7
My motivation is lower when I am fatigued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise brings on my fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am easily fatigued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue interferes with my physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue causes frequent problems for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My fatigue prevents sustained physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue interferes with carrying out certain duties and responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue is among my three most disabling symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue interferes with my work, family or social life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thank you for completing this questionnaire!

Please bring it to your upcoming appointment at the Post COVID-19 Recovery Clinic.

Questionnaire reviewed by:

Signature _____

Printed name _____

Date _____