ECHO Environmental influences on Child Health Outcomes A program supported by the NIH	**COVID-19 Questionnaire – Child Self-Report Primary Version** ECHO-wide Cohort Version 01.30 / April 9, 2020				**Form C19-cPV** Page **1** of **7**
COHORT ID	**SITE ID**	**PARTICIPANT ID**	**PIN**	**COHORT VISIT ID**	**FORM COMPLETED**
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ECHO LIFE STAGE		**RESPONDENT**	
☐ 01 Prenatal	☐ 02 Perinatal	☐ 01 Participant	☐ 02 Biological Mother
☐ 03 Infancy	☐ 04 Early Childhood	☐ 03 Biological Father	☐ 04 Other Respondent
☐ 05 Middle Childhood	☐ 06 Adolescence		→ Code: _ _

STUDY STAFF INSTRUCTION: This form should be completed by the 13- to 21-year-old child enrolled in an ECHO cohort during the adolescence life stage. The child's ID should be used in the header for the participant ID.

INSTRUCTIONS:

This form has 2 sections:

- *Section A: COVID-19 Infection*
- *Section B: Impacts of the COVID-19 Outbreak on You*

These questions are about your experience with COVID-19, or the coronavirus. For each question, do the best you can to remember the details requested.

Section A. COVID-19 Infection

For the following questions, healthcare provider means a doctor, nurse practitioner, physician assistant or anyone you go to for medical care.

1. Has a healthcare provider ever told you that you have, or likely have, COVID-19 (Coronavirus)?

- ☐ 01 Yes
- ☐ 02 No

2. Which of the following symptoms have you had at any point in time since March 1, 2020? (***Mark all that apply***)

- ☐ 01 Fever or chills
- ☐ 02 Cough
- ☐ 03 Shortness of breath
- ☐ 04 Sore throat
- ☐ 05 Headache
- ☐ 06 Muscle or body aches
- ☐ 07 Runny nose
- ☐ 08 Fatigue or excessive sleepiness
- ☐ 09 Diarrhea, nausea, or vomiting
- ☐ 10 Loss of sense of smell or taste
- ☐ 11 Itchy/red eyes
- ☐ 12 None of the above ➔ ***skip to Section A, Question 3.***

2.a. Which of the following occurred as a result of your symptoms? (***Mark all that apply***)

- ☐ 01 I was kept overnight in a hospital because a healthcare provider thought I had COVID-19
- ☐ 02 I saw a healthcare provider in person, such as in a clinic, doctor's office, urgent care, or Emergency Room (ER)/Emergency Department (ED)
- ☐ 03 I spoke to a healthcare provider over the phone, by email, or online
- ☐ 04 I self-isolated or quarantined at home
- ☐ 05 None of the above

2.b. In the two weeks before you had symptoms, did you: (***Mark all that apply***)

- ☐ 01 Have contact with someone who tested positive for COVID-19
- ☐ 02 Have contact with someone who likely had COVID-19 (e.g., was not tested but had symptoms; was told by a healthcare provider that he/she likely had it)
- ☐ 03 Travel to a different state or country (please specify: _____)
- ☐ 04 None of the above

Section A. COVID-19 Infection (continued)

3. Have you had the nose swab test for the virus that causes COVID-19? (***Mark all that apply***)

☐ 01 No, I never tried to get tested

☐ 02 No, I tried to get tested but was not able to

☐ 03 Yes, and I am waiting for the results

***If yes*➔ 3.a.** When was the date of your most recent test? __ __ /__ __ __ __ (*mm* / *yyyy*)

☐ 04 Yes, and the test showed that I do not have it ("**negative**" test)

***If yes* ➔ 3.b.** When was the date of your most recent **negative** test? __ __ /__ __ __ __ (*mm* / *yyyy*)

☐ 05 Yes, and the test showed that I do have it ("**positive**" test)

***If yes* ➔ 3.c.** When was the date of your most recent **positive** test? __ __ /__ __ __ __ (*mm* / *yyyy*)

4. Have you had a blood test to see whether you already had the COVID-19 virus ("serology")? (***Mark all that apply***)

☐ 01 No, I never tried to get tested

☐ 02 No, I tried to get tested but was not able to

☐ 03 Yes, and I am waiting for the results

***If yes* ➔ 4.a.** When was the date of your most recent test? __ __ /__ __ __ __ (*mm* / *yyyy*)

☐ 04 Yes, and the test showed that I did not have it ("**negative**" test)

***If yes* ➔ 4.b.** When was the date of your most recent **negative** test? __ __ /__ __ __ __ (*mm* / *yyyy*)

☐ 05 Yes, and the test showed that I did have it ("**positive**" test)

***If yes* ➔ 4.c.** When was the date of your **positive** test? __ __ /__ __ __ __ (*mm* / *yyyy*)

5. Has anyone else living in your home had, or probably had, COVID-19?

☐ 01 Yes

☐ 02 No

Section B. Impacts of the COVID-19 Outbreak on You

1. In what ways has the COVID-19 outbreak affected your overall healthcare? (***Mark all that apply***)

- ☐ 01 I did not go to healthcare appointments because I was concerned about entering my healthcare provider's office
- ☐ 02 My healthcare provider canceled appointments
- ☐ 03 My healthcare provider changed to phone or online visits
- ☐ 04 My healthcare provider told me to self-isolate or quarantine
- ☐ 05 None of these apply

2. Did your school close because of the COVID-19 outbreak?

- ☐ 01 Yes
- ☐ 02 No ➔ ***Skip to Section B, Question 3***
- ☐ 02 I am not enrolled in any school ➔ ***Skip to Section B, Question 3***

2.a. Do you usually receive free meals at school?

- ☐ 01 Yes
- ☐ 02 No ➔ ***Skip to Section B, Question 2.b***

2.a.1. Has your school offered meals during the school closure from COVID-19?

- ☐ 01 Yes
- ☐ 02 No ➔ ***Skip to Section B, Question 2.b***

2.a.1.a. Have you been able to get the school-provided meals during the COVID-19 associated closure?

- ☐ 01 Yes
- ☐ 02 No

2.b. Has your school offered online learning while closed?

- ☐ 01 Yes
- ☐ 02 No ➔ ***Skip to Section B, Question 3***

2.b.1. Has your school provided either of the following to support online learning?

a. Free home internet access	☐ 01 Yes	☐ 02 No
b. Free computer or tablet	☐ 01 Yes	☐ 02 No

Section B. Impacts of the COVID-19 Outbreak on You (continued)

3. What type of internet access do you have at home? (***Mark all that apply***)

- ☐ 01 High-speed broadband internet ("WiFi") (e.g., DSL, cable, fiber optic)
- ☐ 02 Dial-up internet (not WiFi)
- ☐ 03 Smartphone not connected to WiFi network at home (e.g., use cellular, LTE, mobile hotspot, neighbor's WiFi)
- ☐ 04 I do not have internet access at home

→ ***Skip to Section B, Question 4***

3.b. Did you have high-speed broadband internet access at home prior to March 1, 2020?

- ☐ 01 Yes
- ☐ 02 No

For rows 4.a through 4.h below, please mark 'Less', 'Same amount', or 'More' for how much you are now engaged in the activity compared to before the COVID-19 outbreak.

4. Compared to before the COVID-19 outbreak, how much are you now doing the following:	**Less**	**Same amount**	**More**
a. Eating	☐ 01	☐ 02	☐ 03
b. Sleeping	☐ 01	☐ 02	☐ 03
c. Physical activity	☐ 01	☐ 02	☐ 03
d. Spending time outside	☐ 01	☐ 02	☐ 03
e. Spending time with friends in-person	☐ 01	☐ 02	☐ 03
f. Spending time with friends remotely (e.g., online, social media, texting)	☐ 01	☐ 02	☐ 03
g. Spending time watching TV, playing video/computer games, or using social media for ***educational*** purposes, including school work	☐ 01	☐ 02	☐ 03
h. Spending time watching TV, playing video/computer games, or using social media for ***non-educational*** purposes	☐ 01	☐ 02	☐ 03

5. Compared to before the COVID-19 outbreak, do you feel …

- ☐ 01 much less socially connected
- ☐ 02 less socially connected
- ☐ 03 slightly less socially connected
- ☐ 04 slightly more socially connected
- ☐ 05 more socially connected

☐ 06 much more socially connected

Section B. Impacts of the COVID-19 Outbreak on You (continued)

6. What have you done to cope with your stress related to the COVID-19 outbreak? (***Mark all that apply***)

☐ 01 Meditation and/or mindfulness practices
☐ 02 Engaging in more family activities (e.g., games, sports)
☐ 03 Eating more often, including snacking
☐ 04 Increasing time reading books, or doing activities like puzzles and crosswords
☐ 05 Drinking alcohol
☐ 06 Using tobacco (e.g., smoking; *do not* include vaping)
☐ 07 Using marijuana (e.g., smoking, edibles; *do not* include vaping) or cannabidiol (CBD)
☐ 08 Vaping marijuana
☐ 09 Vaping other substances (e.g., using e-cigarettes, e-juice)
☐ 10 Talking to my healthcare providers more frequently, including mental healthcare provider (e.g., therapist, psychologist, counselor)
☐ 11 Volunteer work
☐ 12 I have not done any of these things to cope with the COVID-19 outbreak

7. Please indicate the extent to which you view the COVID-19 outbreak as having either a positive or negative impact on your life.

☐ 01 Extremely negative
☐ 02 Moderately negative
☐ 03 Somewhat negative
☐ 04 No impact
☐ 05 Slightly positive
☐ 06 Moderately positive
☐ 07 Extremely positive

8. Since becoming aware of the COVID-19 outbreak, how often have you felt happy and satisfied with your life?

☐ 01 Not at all
☐ 02 Rarely
☐ 03 Sometimes
☐ 04 Often
☐ 05 Very often

Section B. Impacts of the COVID-19 Outbreak on You (continued)

For rows 9.a through 9.i below, please mark 'Not at all', 'Rarely', 'Sometimes', 'Often', or 'Very often' for how often you have had the experience since becoming aware of the COVID-19 outbreak.

9. Since becoming aware of the COVID-19 outbreak, how often have you …	**Not at all**	**Rarely**	**Sometimes**	**Often**	**Very often**
a. had difficulty sleeping	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
b. startled easily	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
c. had angry outbursts	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
d. felt a sense of time slowing down	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
e. felt in a daze	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
f. tried to avoid thoughts and feelings about COVID-19	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
g. tried to avoid reading or watching information about COVID-19	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
h. had distressing dreams about COVID-19	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
i. been distressed when I see something that reminds me of COVID-19	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05

Setting	Mode
☐ 01 Clinic or site ☐ 02 Phone ☐ 03 Other location	☐ 01 Self-administered ☐ 02 Staff-administered