Child Birth History

ERROR! You must complete the visit form before you can start this form.

What is the date that this survey is being done?

_____
(MM-DD-YYYY)

Check this box if the coordinator is entering data: ☐ Coordinator data entry

Now we are going to ask you some questions about [sname_your_poss] birth.

What was [sname_your_poss] birth mother's age when [sname_you] [sv_was] born?

◯ Less than 18 years old
◯ 18 to 25 years old
◯ 26 to 34 years old
◯ 35 years old or more
◯ I don't know
◯ I do not want to answer

We would like to know [sname_your_poss] weight at birth. Please tell us if you know [sname_your_poss] birth weight in pounds and ounces, or kilograms and grams.

◯ Pounds and ounces
◯ Kilograms or grams
◯ I don't know
◯ I do not want to answer

How much did [sname_you] weigh when [sname_you] [sv_was] born?Pounds:_____Ounces:_____

Child birth weight in pounds:

_____
(pounds)

Child birth weight in ounces:

_____
(ounces)

How much did [sname_you] weigh when [sname_you] [sv_was] born?Kilograms:_____Grams:_____

Child birth weight in kg:

_____
(kilograms)

Child birth weight in g:

_____
(grams)

We would like to know [sname_your_poss] length at birth. Please let us know if you know [sname_your_poss] birth length in inches or centimeters.

◯ Inches
◯ Centimeters
◯ I don't know
◯ I don't want to answer

How long [sv_was] [sname_you] when [sname_you] [sv_was] born in inches?

_____
(inches)

How long [sv_was] [sname_you] when [sname_you] [sv_was] born in centimeters?

_____
(centimeters)

[sv_was_cap] [sname_you] born prematurely (meaning more than 3 weeks before the due date)?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

How many weeks pregnant was [sname_your_poss] birth mother when [sname_you] [sv_was] born?

_____
(weeks)

How [sv_was] [sname_you] delivered?

◯ Vaginal birth
◯ Birth by cesarean section
◯ I don't know
◯ I do not want to answer

[sv_was_cap] [sname_you] admitted to the neonatal intensive care unit (NICU)?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Did [sname_your_poss] birth mother have any of the following problems while pregnant with [sname_you]? (You can choose one or more of these):

☐ Diabetes, related to the pregnancy (gestational diabetes)
☐ High blood pressure, related to the pregnancy (gestational hypertension)
☐ Preeclampsia (sometimes called "toxemia")
☐ Seizures
☐ Placenta previa (when the placenta covers the opening to the uterus, the cervix)
☐ Placenta abruption (when the placenta breaks off from the uterus)
☐ Uterine rupture (when the wall of the uterus breaks open)
☐ Preterm premature rupture of membranes (when the bag of water breaks at a time when the baby would be born premature)
☐ Amniotic fluid levels that are too high or too low (oligohydramnios or polyhydramnios)
☐ None
☐ Other, please explain: _____
☐ I don't know
☐ I do not want to answer

Please explain what other problems the birth mother had: _____

The next set of questions ask about how [sname] is being fed.

During the first week after [sname] was born, did [sname] breastfeed or drink ANY breast milk?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Is [sname] breastfeeding or drinking ANY breast milk now?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

How old was [sname] when they completely stopped breastfeeding or drinking breast milk? If [sname] never breastfed or drank breast milk, please enter 0 days._____

Child stopped breastfeeding at:

◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10
◯ 11
◯ 12
◯ 13
◯ 14
◯ 15
◯ 16
◯ 17
◯ 18
◯ 19
◯ 20
◯ 21
◯ 22
◯ 23
◯ 24
◯ 25
◯ 26
◯ 27
◯ 28
◯ 29
◯ 30
◯ 31
◯ 32
◯ 0

Day, weeks, or month child stopped breastfeeding:

◯ Days
◯ Weeks
◯ Months

Child Current Health Status

ERROR! You must complete the visit form before you can start this form.

Date when this form was completed:

_____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

We would like to know how long or how tall [sname_you] [sv_is] now. Would you like to tell us [sname_your_poss] height in feet and inches or in centimeters?

◯ Feet and inches
◯ Centimeters
◯ I don't know
◯ I do not want to answer

Currently, how long or how tall [sv_is] [sname_you] without shoes?Feet:_____Inches:_____

Child's heel to head length (feet)

_____

Child's heel to head length (inches)

_____

Currently, how long or how tall [sv_is] [sname_you] without shoes?

_____
(centimeters)

We would like to know how much [sname_you] weigh[sv_3pend] now. Would you like to tell us [sname_your_poss] weight in pounds or in kilograms?

◯ Pounds
◯ Kilograms
◯ I don't know
◯ I do not want to answer

How much [sv_does] [sname_you] weigh without clothes or shoes in pounds?

_____
(pounds)

How much [sv_does] [sname_you] weigh without clothes or shoes in kilograms:

_____
(kilograms)

Next, we will ask questions about [sname_your_poss] birth parents' height and weight.

We would like to know how tall [sname_your_poss] birth mother is. [cchs_bmht_calcya] Would you like to tell us this height in feet and inches or in centimeters?

◯ Feet and inches
◯ Centimeters
◯ I don't know
◯ I do not want to answer

How tall is [sname_your_poss] birth mother without shoes?Feet:_____Inches:_____

Birth mother's heel to head length (feet)

_____

Birth mother's heel to head length (inches)

_____

How tall is [sname_your_poss] birth mother without shoes?

_____
(centimeters)

We would like to know how much [sname_your_poss] birth mother weighs. [cchs_bmwt_calcya] Would you like to tell us this weight in pounds or in kilograms?

◯ Pounds
◯ Kilograms
◯ I don't know
◯ I do not want to answer

How much does [sname_your_poss] birth mother weigh without clothes or shoes in pounds?

_____
(pounds)

How much does [sname_your_poss] birth mother weigh without clothes or shoes in kilograms?

_____
(kilograms)

We would like to know how tall [sname_your_poss] biological father is. [cchs_bfht_calcya] Would you like to tell us this height in feet and inches or in centimeters?

◯ Feet and inches
◯ Centimeters
◯ I don't know
◯ I do not want to answer

How tall is [sname_your_poss] biological father without shoes?Feet:_____Inches:_____

Biological father's heel to head length (feet)

_____

Biological father's heel to head length (inches)

_____

How tall is [sname_your_poss] biological father without shoes?

_____
(centimeters)

We would like to know how much [sname_your_poss] biological father weighs. [cchs_bfwt_calcya] Would you like to tell us this weight in pounds or in kilograms?

◯ Pounds
◯ Kilograms
◯ I don't know
◯ I do not want to answer

How much does [sname_your_poss] biological father weigh without clothes or shoes in pounds?

_____
(pounds)

How much does [sname_your_poss] biological father weigh without clothes or shoes in kilograms?

_____
(kilograms)

[sv_does_cap] [sname_you] have periods or menstruate?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

[sv_does_cap] [sname_you] have any of the following?

	Yes	No	I don't know	I do not want to answer
A lot of trouble paying attention, remembering things, or making decisions because of problem from a physical, mental, or emotional condition	◯	◯	◯	◯
Serious trouble walking or climbing stairs	◯	◯	◯	◯
Trouble getting dressed or taking a bath	◯	◯	◯	◯
Difficulty doing errands alone, such as visiting a doctor's office or shopping, because of a physical, mental, or emotional condition	◯	◯	◯	◯
Deafness or problems with hearing	◯	◯	◯	◯
Blindness or problems with seeing, even when wearing glasses	◯	◯	◯	◯

Right now, does anyone in your household use cigarettes, cigars, or pipe tobacco or vape?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

If yes, does anyone smoke inside your home?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Child Social Determinants Of Health

ERROR! You must complete the visit form before you can start this form.

Date of SDOH data collection: _____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

The next questions ask about your housing.

What best describes your family at home?

◯ Family with 2 generations (for example: child, parents)
◯ Family with 3 generations (for example: child, parents, grandparents)
◯ Family with 4 generations (for example: child, parents, grandparents, great grandparents)
◯ None of these
◯ I do not want to answer

How many adults 18 years or older live in your household? (please include yourself) _____

How many children under 18 years old live in your household? _____

How many rooms are in your house? Please include all rooms such as the kitchen and living room, but not bathrooms or hallways. _____ (number of rooms)

The next question asks about [sname_your_poss] birth order.

How would you describe [sname_your_poss] birth order (the order in which [sname_you] and all of [sname_your_poss] brothers and sisters were born)? For this question, please include [sname_your_poss] biological, half, and step-siblings, whether or not they live in the same home.

◯ [sname_i] [sv_is] the only child
◯ 1st born: [sname_i] [sv_is] the first child born and the oldest
◯ 2nd born: [sname_i] [sv_is] the second child born
◯ 3rd born: [sname_i] [sv_is] the third child born
◯ 4th born: [sname_i] [sv_is] the fourth child born
◯ 5th born: [sname_i] [sv_is] the fifth child born
◯ 6th born: [sname_i] [sv_is] the sixth child born
◯ 7th born: [sname_i] [sv_is] the seventh child born
◯ 8th born: [sname_i] [sv_is] the eighth child born
◯ 9th born: [sname_i] [sv_is] the ninth child born
◯ 10th born or more: [sname_i] [sv_is] the tenth child born or more
◯ I don't know
◯ I do not want to answer

Are you currently living in transitional housing (housing that is for the time being, not somewhere to stay long term), staying in a shelter, or experiencing homelessness (no place to live)?

◯ Yes
◯ No
◯ I do not want to answer

Which best describes the place in which [sph_youand_you] live?

◯ A one-family house detached (separate) from any other house
◯ A townhouse, row house, apartment, or condo of 2 to 4 units
◯ An apartment or condo with 5 to 19 units
◯ An apartment or condo with 20 or more units
◯ Residential care for people with intellectual and developmental disabilities (place where people live because of things like problems with development)
◯ Psychiatric treatment facility (place where mental health problems are treated)
◯ Other group home setting
◯ Foster care
◯ Somewhere else
◯ I do not want to answer

What is your current marital status?

◯ Married
◯ Divorced
◯ Widowed
◯ Separated
◯ Never Married
◯ Living with partner
◯ I do not want to answer

What is the current marital status of your parents?

◯ Married
◯ Divorced
◯ Widowed
◯ Separated
◯ Never Married
◯ Living with partner
◯ I do not want to answer

The next questions ask about [sname_your_poss] health care.

DURING THE PAST 12 MONTHS, did [sname_you] see a doctor, nurse, or other health care professional for sick-child care, well-child check-ups, physical exams, hospitalizations or any other kind of medical care?

◯ Yes
◯ No

DURING THE PAST 12 MONTHS, how many times did [sname_you] visit a doctor, nurse, or other health care professional to receive a PREVENTIVE check-up? A preventive check-up is when [sname_you] was not sick or injured, such as an annual or sports physical, or well-child visit.

◯ 0 visits
◯ 1 visit
◯ 2 or more visits
◯ I don't know
◯ I do not want to answer

Is there a place that you USUALLY go to if [sname_you] [sv_is] sick and need[sv_3pend] health care?

◯ Yes
◯ There is NO place
◯ There is MORE THAN ONE place
◯ I don't know
◯ I do not want to answer

What kind of place do you go to most often?

◯ A doctor's office or health center
◯ An urgent care center (a place where you can walk in to get care right away without an appointment)
◯ A hospital emergency room
◯ [sname_my_poss_cap] school
◯ Some other place
◯ Do not go to one place most often
◯ I don't know
◯ I do not want to answer

DURING THE PAST 12 MONTHS, how many times did [sname_you] visit a doctor, nurse, or other health care professional to receive SICK care? Sick care is a visit with a doctor, nurse or other health professional when this child was sick or injured.

◯ 0 visits
◯ 1 visit
◯ 2 or more visits
◯ I don't know
◯ I do not want to answer

During the past 12 months, how many times [sv_has] [sname_you] gone to an urgent care center about [sp_their_your] health?

◯ 0 visits
◯ 1 visit
◯ 2 or more visits
◯ I don't know
◯ I do not want to answer

DURING THE PAST 12 MONTHS, how many times [sv_has] [sname_you] gone to a hospital emergency room about [sp_their_your] health?

◯ 0 visits
◯ 1 visit
◯ 2 or more visits
◯ I don't know
◯ I do not want to answer

During the past 12 months, [sv_has] [sname_you] needed to stay overnight in a hospital?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

During the past 12 months, was there any time when [sname_you] needed medical care, but DID NOT GET IT because of the cost?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

The next questions will ask about written information that you may have been given in the hospital or by your doctor.

How often do you have someone (like a family member, friend, or hospital worker) help you read hospital materials?

◯ Always
◯ Often
◯ Sometimes
◯ Occasionally
◯ Never

How often do you have problems learning about your medical condition because of difficulty understanding written information?

◯ Always
◯ Often
◯ Sometimes
◯ Occasionally
◯ Never

How confident are you filling out medical forms by yourself?

◯ Extremely
◯ Quite a bit
◯ Somewhat
◯ A little bit
◯ Not at all

The next questions ask about [sname_your_poss] health insurance.

[sv_is_cap] [sname_you] currently covered by any of the following types of health insurance or health coverage plans? Choose one or more of these.

☐ Insurance purchased directly from an insurance company (by you or another family member)
☐ Insurance through a current or former employer or union (someone you worked or work for or a group that protects the rights of workers)
☐ Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or disability or state-provided health insurance for children
☐ Indian Health Service
☐ TRICARE or other military health care
☐ [sname_i] [sv_does] not have health insurance, self-pay
☐ I don't know what kind of health insurance [sname_i] [sv_has]
☐ I do not want to answer
☐ Other, please explain

Please specify other health insurance or health coverage: _____

Did [sname_you] lose health coverage (health insurance) because of the COVID pandemic?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Since the COVID pandemic reached the United States in March 2020, please tell us how true the following sentences are, on a scale of 1-5, where 1 is not at all true, and 5 is completely true.

	1 - Not at all true	2	3	4	5 - Completely true
All [sname_my_poss] important health care needs have been met.	◯	◯	◯	◯	◯
I was able to get all the health care visits I thought I needed for [sname_myself].	◯	◯	◯	◯	◯
I was able to get all of the medical equipment or supplies I thought [sname_i] needed.	◯	◯	◯	◯	◯
I can reach a doctor or nurse when I need one	◯	◯	◯	◯	◯
I have access to WiFi	◯	◯	◯	◯	◯
I have to be careful about how much WiFi I use because I can only have a certain amount of data I can use.	◯	◯	◯	◯	◯
I am able to use a tablet or computer that is connected to the internet when I need to	◯	◯	◯	◯	◯
[sname_i] [sv_has] had at least one telemedicine visit with a nurse or doctor. (A telemedicine visit is a visit not done in-person, including a visit done by talking over the phone or by using video call.)	◯	◯	◯	◯	◯
I am able to explain [sname_my_poss] health problems well in a telemedicine appointment.	◯	◯	◯	◯	◯
I think my doctor is able to get a good understanding of [sname_my_poss] health problems during a telemedicine appointment.	◯	◯	◯	◯	◯

Now, please tell us how often [sname_you] did the following things in the past 30 days.

	Always	Often	Sometimes	Rarely	Never
I avoided having [sname] be near other people	◯	◯	◯	◯	◯
[sname] wore a mask when outside in public	◯	◯	◯	◯	◯
[sname] wore a mask when inside in public	◯	◯	◯	◯	◯

[sname] wore a mask when in school	○	○	○	○	○
I avoided having [sname] go to gatherings of 10 people or more	○	○	○	○	○
I avoided having [sname] eat in restaurants	○	○	○	○	○
I avoided having [sname] shop in stores (including grocery stores and pharmacies)	○	○	○	○	○
I avoided having [sname] play in parks and playgrounds	○	○	○	○	○
I avoided having [sname] take public transportation	○	○	○	○	○

	Always	Often	Sometimes	Rarely	Never
I avoided being near other people	○	○	○	○	○
I wore a mask when outside in public	○	○	○	○	○
I wore a mask when inside in public	○	○	○	○	○
I wore a mask when in school	○	○	○	○	○
I avoided going to gatherings of 10 people or more	○	○	○	○	○
I avoided eating in restaurants	○	○	○	○	○
I avoided shopping in stores (including grocery stores and pharmacies)	○	○	○	○	○
I avoided playing in parks and playgrounds	○	○	○	○	○
I avoided taking public transportation	○	○	○	○	○

Why did you rarely or never avoid having [sname] do these things? Choose one or more of these.

☐ A doctor or healthcare provider did not recommend it
☐ My friends and family did not recommend it
☐ I have read information that suggests it is unsafe
☐ [sname] is at low risk of getting sick from COVID
☐ I do not trust the government
☐ I do not trust the research
☐ [sname] already had a COVID infection
☐ Other

If other, please specify: _____

Why did [sname_you] rarely or never wear a mask outside or inside in public or in school? Choose one or more of these.

☐ A doctor or healthcare provider did not recommend it
☐ My friends and family did not recommend it
☐ I have read information that suggests it is unsafe
☐ [sname_i] [sv_is_am] at low risk of getting sick from COVID
☐ I do not trust the government
☐ I do not trust the research
☐ [sname_i] already had a COVID infection
☐ Other

If other, please specify:

_____

The COVID pandemic may cause difficulties or problems for some people, whether they get COVID or not. Since the pandemic began in March 2020 through today, have you and your family experienced any of the following difficulties or problems?

Having a place to stay or live

◯ No, not a problem
◯ Yes, a small problem
◯ Yes, a big problem

Has this been a problem in the last 6 months?

◯ Yes
◯ No

Getting enough food to eat

◯ No, not a problem
◯ Yes, a small problem
◯ Yes, a big problem

Has this been a problem in the last 6 months?

◯ Yes
◯ No

Having clean water to drink

◯ No, not a problem
◯ Yes, a small problem
◯ Yes, a big problem

Has this been a problem in the last 6 months?

◯ Yes
◯ No

Getting to where I need to go

◯ No, not a problem
◯ Yes, a small problem
◯ Yes, a big problem

Has this been a problem in the last 6 months?

◯ Yes
◯ No

Now we are going to ask about your household finances, or the amount of money you and the people in your home have. We are asking about this because we would like to know how COVID has affected this.

What is your total household income before taxes?

◯ Less than $15,000
◯ $15,000 - $19,999
◯ $20,000 - $24,999
◯ $25,000 - $34,999
◯ $35,000 - $49,999
◯ $50,000 - $74,999
◯ $75,000 - $99,999
◯ $100,000 and above
◯ I do not want to answer

Has your household income changed significantly since March 2020? (please DO NOT INCLUDE money you got from the government (called a stimulus payment) if you have got one)

◯ Yes, my household income is less
◯ Yes, my household income is more
◯ No, my household income is about the same
◯ I do not want to answer

Have you, or has anyone in your household, experienced a loss of employment income (lost a job where they were making money) since the start of the COVID pandemic (March 2020)?

◯ Yes
◯ No
◯ I do not want to answer

In the past month, how difficult has it been for you to cover your household expenses and pay all the household bills?

◯ Very difficult
◯ Somewhat difficult
◯ Not at all difficult
◯ I don't know
◯ I do not want to answer

Are you currently getting help from any of the following programs?

	Received	Applied and waiting to receive	Tried but was not able to get the help	Did not try to get help
Unemployment Insurance	◯	◯	◯	◯
SNAP (Supplemental Nutrition Assistance Program) or Food Stamps	◯	◯	◯	◯
TANF (Temporary Assistance for Needy Families)	◯	◯	◯	◯

WIC (Women, Infants, And Children Assistance)	◯	◯	◯	◯
Social Security	◯	◯	◯	◯
Supplemental Social Security	◯	◯	◯	◯
Any kind of government health insurance or health coverage plan including Medicaid, Medical Assistance, or Medicare	◯	◯	◯	◯
Paycheck Protection Program	◯	◯	◯	◯
Other aid from the government	◯	◯	◯	◯
Help or assistance from a union or other association	◯	◯	◯	◯
Help or assistance from a church or religious organization	◯	◯	◯	◯
Help or assistance from another community organization	◯	◯	◯	◯
A food pantry	◯	◯	◯	◯
Other help or assistance	◯	◯	◯	◯

Please explain what other financial assistance you tried to apply for:

The next questions ask about having enough food to eat during the last 12 months.For these statements, please answer whether the statement was often true, sometimes true, or never true for (you or your household) in the last 12 months.

"We worried whether our food would run out before we got money to buy more." Was that often true, sometimes true, or never true for your household in the last 12 months?

◯ Often true
◯ Sometimes true
◯ Never true
◯ I don't know
◯ I do not want to answer

"The food that we bought just didn't last, and we didn't have money to get more." Was that often, sometimes, or never true for your household in the last 12 months?

◯ Often true
◯ Sometimes true
◯ Never true
◯ I don't know
◯ I do not want to answer

"We couldn't afford to eat balanced meals." Was that often, sometimes, or never true for your household in the last 12 months?

◯ Often true
◯ Sometimes true
◯ Never true
◯ I don't know
◯ I do not want to answer

In the last 12 months, did anyone in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

How often did this happen?

◯ Almost every month
◯ Some months but not every month
◯ Only 1 or 2 months
◯ I don't know
◯ I do not want to answer

In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

In the last 12 months, were others in your household ever hungry but didn't eat because there wasn't enough money for food?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

In the last 12 months, did others in your household lose weight because there wasn't enough money for food?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

In the last 12 months, did others in your household ever not eat for a whole day because there wasn't enough money for food?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

How often did this happen?

◯ Almost every month
◯ Some months but not every month
◯ Only 1 or 2 months
◯ I don't know
◯ I do not want to answer

In [sname_your_poss] day-to-day life, how often do you think any of the following things happen to [sname_you]?

	Almost every day	At least once a week	A few times a month	A few times a year	Less than once a year	Never
[sname_you] [sv_is] treated with less courtesy than other children. By less courtesy we mean that people are not polite (do not have good manners) when they are with [sname_you].	◯	◯	◯	◯	◯	◯
[sname_you] [sv_is] treated with less respect than other [sn_children].	◯	◯	◯	◯	◯	◯
[sname_you] received poorer service (less help) than other [sn_children] at restaurants or stores.	◯	◯	◯	◯	◯	◯
People act as if they think [sname_you] [sv_is] not smart.	◯	◯	◯	◯	◯	◯
People act as if they are afraid of [sname_you].	◯	◯	◯	◯	◯	◯
People act as if they think [sname_you] [sv_is] dishonest.	◯	◯	◯	◯	◯	◯
People act as if they're better than [sname_you].	◯	◯	◯	◯	◯	◯
[sname_you] [sv_is] called names or insulted.	◯	◯	◯	◯	◯	◯
[sname_you] [sv_is] threatened or harassed.	◯	◯	◯	◯	◯	◯
[sname_you] [sv_is] discriminated against, hassled, or made to feel inferior while getting medical care. By inferior, we mean less important.	◯	◯	◯	◯	◯	◯

What do you think are all the reasons for these experiences? Choose one or more of these.

☐ [sname_my_poss_cap] ancestry or national origins
☐ [sname_my_poss_cap] gender
☐ [sname_my_poss_cap] race
☐ [sname_my_poss_cap] age
☐ [sname_my_poss_cap] religion
☐ [sname_my_poss_cap] height
☐ [sname_my_poss_cap] weight
☐ Some other aspect of [sname_my_poss] physical appearance
☐ [sname_my_poss_cap] sexual orientation
☐ [sname_my_poss_cap] education or income level
☐ A physical disability (a health issue that affects how a person moves)
☐ [sname_my_poss_cap] shade of skin color
☐ [sname_my_poss_cap] tribe
☐ Other _____
☐ I do not want to answer

Other (please specify)

_____

What do you think is the main reason for these experiences?

◯ [sname_my_poss_cap] ancestry or national origins
◯ [sname_my_poss_cap] gender
◯ [sname_my_poss_cap] race
◯ [sname_my_poss_cap] age
◯ [sname_my_poss_cap] religion
◯ [sname_my_poss_cap] height
◯ [sname_my_poss_cap] weight
◯ Some other aspect of [sname_my_poss] physical appearance
◯ [sname_my_poss_cap] sexual orientation
◯ [sname_my_poss_cap] education or income level
◯ A physical disability (a health issue that affects how a person moves)
◯ [sname_my_poss_cap] shade of skin color
◯ [sname_my_poss_cap] tribe
◯ Other _____
◯ I do not want to answer

Other (please specify)

_____

Next, please let us know if the following is true about your household or family.

	Yes	No	I do not want to answer
Household members support each other and have warm relationships.	◯	◯	◯
Household members often bully or fight with each other.	◯	◯	◯
There is a lot of violence in our neighborhood.	◯	◯	◯

Since [sname_you] [sv_was] born, a household member has served time in jail.	○	○	○
Since [sname_you] [sv_was] born, a household member was depressed, mentally ill, or attempted suicide.	○	○	○
Since [sname_you] [sv_was] born, a household member has had a problem with using drugs or alcohol.	○	○	○
Since [sname_you] [sv_was] born, there has been a divorce or separation in your household.	○	○	○

The next questions ask you about your feelings and thoughts during the COVID pandemic in the last month. In each case, you will be asked to tell us how often you felt or thought a certain way.

	Never	Almost never	Sometimes	Fairly often	Very often
In the last month, how often have you been upset because of something that happened unexpectedly (in a way you did not expect)?	○	○	○	○	○
In the last month, how often have you felt that you were unable to control the important things in your life?	○	○	○	○	○
In the last month, how often have you felt nervous and "stressed"?	○	○	○	○	○
In the last month, how often have you felt confident about your ability to handle your personal problems?	○	○	○	○	○
In the last month, how often have you felt that things were going your way?	○	○	○	○	○
In the last month, how often have you found that you could not cope with (handle) all the things that you had to do?	○	○	○	○	○

In the last month, how often have you been able to control irritations (or things that bother you) in your life?	○	○	○	○	○
In the last month, how often have you felt that you were on top of things?	○	○	○	○	○
In the last month, how often have you been angered because of things that were outside of your control?	○	○	○	○	○
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	○	○	○	○	○

The questions below ask about things that might have bothered [sname]. For each question, pick the number that best describes how much (or how often) [sname] has been bothered by each problem during the past TWO (2) WEEKS.

	None (not at all)	Slight (rare, less than a day or two)	Mild (several days)	Moderate (more than half the days)	Severe (nearly every day)
Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	○	○	○	○	○
Had less fun doing things than he/she used to?	○	○	○	○	○
Seemed sad or depressed for several hours?	○	○	○	○	○
Seemed more irritated or easily annoyed than usual?	○	○	○	○	○
Seemed angry or lost his/her temper?	○	○	○	○	○
Started lots more projects than usual or did more risky things than usual?	○	○	○	○	○
Slept less than usual for him/her, but still had lots of energy?	○	○	○	○	○
Said he/she felt nervous, anxious, or scared?	○	○	○	○	○
Not been able to stop worrying?	○	○	○	○	○

Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	○	○	○	○	○
Said that he/she heard voices-when there was no one there-speaking about him/her or telling him/her what to do or saying bad things to him/her?	○	○	○	○	○
Said that he/she had a vision when he/she was completely awake-that is, saw something or someone that no one else could see?	○	○	○	○	○
Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	○	○	○	○	○
Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	○	○	○	○	○
Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	○	○	○	○	○
Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	○	○	○	○	○

You answered that [sname] said he/she had been hearing voices, seeing visions, or having thoughts coming into his/her head in the past two weeks. You can get help to talk about these concerns by contacting [snameposs] health care provider or mental health care provider if [sname] is in mental health care. If you feel that [sname] may take risky actions due to these experiences, crisis services are available by calling 911. You can also go to your local emergency room for help. Please note a member of the study team may call you to follow up in the coming days but this is not a replacement for clinical care or emergency services.

People sometimes look to others for company, help, or other kinds of support. How often is each of the following kinds of support available to you now if you need it?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Someone to help you if you had to stay in bed?	○	○	○	○	○
Someone to take you to the doctor if you needed it?	○	○	○	○	○
Someone to prepare your meals if you were not able to do it yourself?	○	○	○	○	○
Someone to help with daily chores if you were sick and you needed to care for yourself?	○	○	○	○	○
Someone to turn to for suggestions about how to deal with a problem?	○	○	○	○	○
Someone to have a good time with?	○	○	○	○	○
Someone who understands your problems?	○	○	○	○	○
Someone to love and make you feel wanted?	○	○	○	○	○

Next we will ask you questions about your neighborhood.

Please tell us if you agree or disagree with the following statements about your neighborhood. For these questions, please think about your street and the surrounding streets.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
There is a lot of graffiti.	○	○	○	○	○
My neighborhood is noisy.	○	○	○	○	○
Vandalism is common.	○	○	○	○	○
There are a lot of abandoned buildings.	○	○	○	○	○
My neighborhood is clean.	○	○	○	○	○
People take good care of their houses.	○	○	○	○	○
People take good care of their yards.	○	○	○	○	○
There is a lot of criminal activity.	○	○	○	○	○

The next statements are about things that people in your neighborhood may or may not do. For each of these statements, please tell me whether you strongly agree, agree, disagree or strongly disagree.

	Strongly agree	Agree	Disagree	Strongly disagree
People in this neighborhood help each other out.	○	○	○	○

There are people I can count on in this neighborhood.	○	○	○	○
People in this neighborhood can be trusted.	○	○	○	○
This is a close-knit neighborhood (a neighborhood where people know each other well).	○	○	○	○

COVID Family Infection

ERROR! You must complete the visit form before you can start this form.

Form collection date: _____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

Now we will ask you about COVID infections in [sname_your_poss] family.

Were any members of [sname_your_poss] household (other than [sname_yourself]) ever infected with COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

If yes, who? Choose one or more of these

☐ [sname_my_poss_cap] parent
☐ [sname_my_poss_cap] grandparent
☐ [sname_my_poss_cap] sibling
☐ Other, please explain _____

Please explain what other member of the household you think had a COVID infection: _____

Was someone close to [sname_you] hospitalized with COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

If yes, who? Choose one or more of these

☐ [sname_my_poss_cap] parent
☐ [sname_my_poss_cap] grandparent
☐ [sname_my_poss_cap] sibling
☐ [sname_my_poss_cap] friend
☐ Other, please explain _____

Please explain who was hospitalized with COVID: _____

Did someone close to [sname_you] die due to COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

If yes, who? Choose one or more of these

☐ [sname_my_poss_cap] parent
☐ [sname_my_poss_cap] grandparent
☐ [sname_my_poss_cap] sibling
☐ [sname_my_poss_cap] friend
☐ Other, please explain _____

Please explain who died from due to COVID

_____

COVID Health Consequences

ERROR! You must complete the visit form before you can start this form.

What is the date that this survey is being done?

_____
(MM-DD-YYYY)

Check this box if the coordinator is entering data: ☐ Coordinator data entry

The next questions will ask about [sname_your_poss] health overall. Other than getting infected with COVID, children have been affected by COVID in other ways. We want to know about the different ways COVID has affected [sname_your_poss] health during the COVID pandemic. A pandemic is an outbreak of an illness across a whole country or the world. The COVID pandemic began in March 2020.

Next, we will ask about [sname_your_poss] body weight.

How do you describe [sname_your_poss] weight?

◯ Very underweight
◯ Slightly underweight
◯ About the right weight
◯ Slightly overweight
◯ Very overweight
◯ I do not want to answer

Which of the following are [sph_youand_you] trying to do about [sname_your_poss] weight?

◯ Lose weight
◯ Gain weight
◯ Stay the same weight
◯ I am not trying to do anything about [sname_my_poss] weight
◯ I do not want to answer

In general, how has the COVID pandemic affected [sname_your_poss] weight?

◯ Made [sname_me] lose a lot of weight
◯ Made [sname_me] lose a little weight
◯ Made [sname_me] gain a little weight
◯ Made [sname_me] gain a lot of weight
◯ Did not affect [sname_my_poss] weight
◯ I do not want to answer

The next questions ask about food [sname_you] ate or drank during the past 7 days. Think about all the meals and snacks [sname_you] had from the time [sname_you] got up until [sname_you] went to bed. Be sure to include the food [sname_you] ate at home, at school, at restaurants, or anywhere else.

During the past 7 days, how many times did [sname_you] drink 100% fruit juices such as orange juice, apple juice, or grape juice? (Do not count punch, Kool-Aid, sports drinks, or other fruit-flavored drinks.)

◯ [sname_i] did not drink 100% fruit juice during the past 7 days
◯ 1 to 3 times during the past 7 days
◯ 4 to 6 times during the past 7 days
◯ 1 time per day
◯ 2 times per day
◯ 3 times per day
◯ 4 or more times per day
◯ I do not want to answer

In general, how has the COVID pandemic affected the amount of 100% juice [sname_you] drink[sv_3pend]?

◯ Drink[sv_3pend] 100% juice a lot more
◯ Drink[sv_3pend] 100% juice more
◯ Drink[sv_3pend] 100% juice less
◯ Drink[sv_3pend] 100% juice a lot less
◯ Did not affect what [sname_i] drink[sv_3pend]
◯ I do not want to answer

During the past 7 days, how many times did [sname_you] eat fruit? (Do not count fruit juice.)

◯ [sname_i] did not eat fruit during the past 7 days
◯ 1 to 3 times during the past 7 days
◯ 4 to 6 times during the past 7 days
◯ 1 time per day
◯ 2 times per day
◯ 3 times per day
◯ 4 or more times per day
◯ I do not want to answer

During the past 7 days, how many times did [sname_you] eat vegetables? (Examples include green salad, potatoes, carrots, broccoli. Do not include French fries, fried potatoes, potato chips.)

◯ [sname_i] did not eat other vegetables during the past 7 days
◯ 1 to 3 times during the past 7 days
◯ 4 to 6 times during the past 7 days
◯ 1 time per day
◯ 2 times per day
◯ 3 times per day
◯ 4 or more times per day
◯ I do not want to answer

In general, how has the COVID pandemic affected amount of fruit and vegetables [sname_you] eat[sv_3pend]?

◯ Eat[sv_3pend] fruit and vegetables a lot more
◯ Eat[sv_3pend] fruit and vegetables more
◯ Eat[sv_3pend] fruit and vegetables less
◯ Eat[sv_3pend] fruit and vegetables a lot less
◯ Did not affect [sname_my_poss] eating of fruit and vegetables
◯ I do not want to answer

During the past 7 days, how many times did [sname_you] drink a can, bottle, or glass of a sugar-sweetened drink? Examples include soda or pop (such as Coke, Pepsi, or Sprite) or sports drink such as Gatorade or Powerade? (Do not count diet soda or diet pop.)

◯ [sname_i] did not drink soda or pop during the past 7 days
◯ 1 to 3 times during the past 7 days
◯ 4 to 6 times during the past 7 days
◯ 1 time per day
◯ 2 times per day
◯ 3 times per day
◯ 4 or more times per day
◯ I do not want to answer

In general, how has the COVID pandemic affected the amount of soda or other sugary drinks [sname_you] drink[sv_3pend]?

◯ Drink[sv_3pend] soda or sugary drinks a lot more
◯ Drink[sv_3pend] soda or sugary drinks more
◯ Drink[sv_3pend] soda or sugary drinks less
◯ Drink[sv_3pend] soda or sugary drinks a lot less
◯ Did not affect what [sname_i] drink[sv_3pend]
◯ I do not want to answer

During the past 7 days, on how many days did [sname_you] eat breakfast?

◯ 0 days
◯ 1 day
◯ 2 days
◯ 3 days
◯ 4 days
◯ 5 days
◯ 6 days
◯ 7 days
◯ I do not want to answer

In general, how has the COVID pandemic affected how often [sname_you] eat[sv_3pend] breakfast?

◯ Eat[sv_3pend] breakfast a lot more
◯ Eat[sv_3pend] breakfast a little more
◯ Eat[sv_3pend] breakfast a little less
◯ Eat[sv_3pend] breakfast a lot less
◯ Did not affect how often [sname_i] eat[sv_3pend] breakfast
◯ I do not want to answer

The next questions ask about physical activity.

During the past 7 days, on how many days [sv_was] [sname_you] physically active for a total of at least 60 minutes per day? (Add up all the time [sname_you] spent in any kind of physical activity that increased [sp_their_your] heart rate and made [sp_them_you] breathe hard some of the time.)

◯ 0 days
◯ 1 day
◯ 2 days
◯ 3 days
◯ 4 days
◯ 5 days
◯ 6 days
◯ 7 days
◯ I do not want to answer

In general, how has the COVID pandemic affected [sname_your_poss] physical activity?

◯ [sname_i] [sv_is] a lot more physically active
◯ [sname_i] [sv_is] a little more physically active
◯ [sname_i] [sv_is] a little less physically active
◯ [sname_i] [sv_is] a lot less physically active.
◯ Did not affect [sname_my_poss] physical activity
◯ I do not want to answer

Now think about a typical weekday in the last month. How much time would you say [sname_you] spend[sv_3pend] playing outdoors on a typical weekday?_____

Weekday outdoor time units

◯ Hours
◯ Minutes

Weekday outdoor time hours

_____
(hours)

Weekday outdoor time minutes

_____
(minutes)

Now think about a typical weekend day in the last month. How much time would you say [sname_you] spend[sv_3pend] playing outdoors on a typical weekend day?_____

Weekend outdoor time units

◯ Hours
◯ Minutes

Weekend outdoor time hours

_____
(hours)

Weekend outdoor time minutes

_____
(minutes)

In general, how has the COVID pandemic affected [sname_your_poss] outdoor play?

◯ [sname_i] play[sv_3pend] outdoors a lot more
◯ [sname_i] play[sv_3pend] outdoors more
◯ [sname_i] play[sv_3pend] outdoors less
◯ [sname_i] play[sv_3pend] outdoors a lot less
◯ Did not affect [sname_my_poss] outdoor play
◯ I do not want to answer

The next questions ask about [sname_your_poss] screen time. Screen time means watching anything on a TV, smartphone, tablet or computer, or playing video or computer games. Screen time does NOT include time spent on screens for school or homework.

On a weekday (Monday to Friday), how many hours [sv_does] [sname_you] watch screens (count time watching anything on a TV, smartphone, tablet or computer; do not count school work)?

◯ [sname_i] [sv_does] not watch screens on an average weekday
◯ Less than 1 hour per day
◯ 1 hour per day
◯ 2 hours per day
◯ 3 hours per day
◯ 4 hours per day
◯ 5 or more hours per day

On a weekday (Monday to Friday), how many hours [sv_does] [sname_you] play video or computer games or use a computer for something that is not school work? (Count time spent playing games, texting, or using social media on your smartphone, computer, Xbox, PlayStation, iPad, or other tablet; do not count school work)

◯ [sname_i] [sv_does] not play video or computer games or use a computer for something that is not school work
◯ Less than 1 hour per day
◯ 1 hour per day
◯ 2 hours per day
◯ 3 hours per day
◯ 4 hours per day
◯ 5 or more hours per day

On a weekend (Saturday and Sunday), how many hours [sv_does] [sname_you] watch screens (count time watching anything on a TV, smartphone, tablet or computer; do not count school work)?

◯ [sname_i] [sv_does] not watch TV on an average weekend day
◯ Less than 1 hour per day
◯ 1 hour per day
◯ 2 hours per day
◯ 3 hours per day
◯ 4 hours per day
◯ 5 or more hours per day

On a weekend (Saturday and Sunday), how many hours [sv_does] [sname_you] play video or computer games or use a computer for something that is not school work? (Count time spent playing games, texting, or using social media on your smartphone, computer, Xbox, PlayStation, iPad, or other tablet; do not count school work)

◯ [sname_i] [sv_does] not play video or computer games or use a computer for something that is not school work
◯ Less than 1 hour per day
◯ 1 hour per day
◯ 2 hours per day
◯ 3 hours per day
◯ 4 hours per day
◯ 5 or more hours per day

In general, how has the COVID pandemic affected [sname_your_poss] screen time? (Do not include screen time for school work).

◯ [sname_i] [sv_has] a lot more screen time
◯ [sname_i] [sv_has] a little more screen time
◯ [sname_i] [sv_has] a little less screen time
◯ [sname_i] [sv_has] a lot less screen time
◯ Did not affect [sname_my_poss] screen time
◯ I do not want to answer

The next questions ask about [sname_your_poss] sleep. Please count all sleep time, including nap time.

On a weekday (Monday to Friday), how many hours of sleep [sv_does] [sname_you] get?

◯ 4 or less hours
◯ 5 hours
◯ 6 hours
◯ 7 hours
◯ 8 hours
◯ 9 hours
◯ 10 or more hours
◯ I do not want to answer

On a weekend (Saturday and Sunday), how many hours of sleep [sv_does] [sname_you] get?

◯ 4 or less hours
◯ 5 hours
◯ 6 hours
◯ 7 hours
◯ 8 hours
◯ 9 hours
◯ 10 or more hours

In general, how has the COVID pandemic affected [sname_your_poss] sleep?

◯ Sleep[sv_3pend] a lot more
◯ Sleep[sv_3pend] a little more
◯ Sleep[sv_3pend] a little less
◯ Sleep[sv_3pend] a lot less
◯ Did not affect [sname_my_poss] sleep
◯ I do not want to answer

What type of school [sv_was] [sname_you] in from Fall 2019 to now? Choose the kind of school [sname_you] [sv_was] in during each part of the school year between Fall 2019 and now.

	Full time in person (at school)	Full time remote (not in school)	Hybrid (both in person [at school] and remote [not in school])	[sname_i] was not in school	I do not want to answer
Fall 2019 to Winter 2020	☐	☐	☐	☐	☐
Spring 2020	☐	☐	☐	☐	☐
Fall 2020 to Winter 2021	☐	☐	☐	☐	☐
Spring 2021	☐	☐	☐	☐	☐
Fall 2021 to Winter 2022	☐	☐	☐	☐	☐
Spring 2022	☐	☐	☐	☐	☐
Fall 2022 to Winter 2023	☐	☐	☐	☐	☐
Spring 2023	☐	☐	☐	☐	☐
Fall 2023 to Winter 2024	☐	☐	☐	☐	☐
Spring 2024	☐	☐	☐	☐	☐

How many times did [sname_your_poss] school or classroom close during the 2020-2021 school year?

◯ 0 - there weren't any closures
◯ 1 to 5 times
◯ 6 to10 times
◯ More than 10 times
◯ I do not want to answer

How many times did [sname_your_poss] school or classroom close during the 2021-2022 school year?

◯ 0 - there weren't any closures
◯ 1 to 5 times
◯ 6 to10 times
◯ More than 10 times
◯ I do not want to answer

In general, how has the COVID pandemic affected [sname_your_poss] grades?

◯ Made it a lot better
◯ Made it a little better
◯ Made it a little worse
◯ Made it a lot worse
◯ Did not affect [sname_my_poss] grades
◯ [sname_i] [sv_does] not get grades at school
◯ I do not want to answer

The next questions ask about any services [sname_you] get[sv_3pend].

[sv_does_cap] [sname_you] have an Individualized Education Program (IEP) or [sv_is] [sname_you] in the process of getting an IEP? An IEP is a plan to give services or special education for children with special needs (like developmental delays, disabilities, reading or math problems, or autism). It can include different services, like speech, occupational or physical therapy.

◯ Yes, [sname_i] [sv_has] and IEP
◯ No, [sname_i] [sv_does] not have an IEP
◯ [sname_i] [sv_is] in the process of getting an IEP
◯ I don't know
◯ I do not want to answer

If yes, for what type of services (Choose one or more of these):

☐ Speech therapy
☐ Occupational therapy
☐ Physical therapy
☐ Behavioral services or supports
☐ Special education services (in the class or outside of the class)
☐ Other _____

If other, please explain

_____

[sv_does_cap] [sname_you] get Early Intervention (EI)? Early intervention gives services for young children with special needs (developmental delays or disabilities). It can include different services, like speech, occupational or physical therapy. Services can be given in your home, or in child care centers and early childhood programs.

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

If yes, for what type of services (Choose one or more of these):

☐ Speech therapy
☐ Occupational therapy
☐ Physical therapy
☐ Behavioral services or supports
☐ Special instruction
☐ Other _____

If other, please explain

_____

In general, how has the COVID pandemic affected [sname_your_poss] services?

◯ Made them a lot better
◯ Made them a little better
◯ Made them a little worse
◯ Made them a lot worse
◯ Did not affect [sname_my_poss] services

Have [sph_youand_you] ever been a part of a home visiting program? Home visiting is when social workers, parent educators, or registered nurses visit families with pregnant mothers and babies in the home. The visitors provide health check-ups and referrals, parenting advice and help with getting other government programs.

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

The next questions ask about discipline. Parents use many options to discipline their children and no parent does it right 100% of the time. Please let us know what you do, not what you think you should do.

In the past month, what have you done when [sname] needed to be disciplined?

	Yes	No	I don't know	I do not want to answer
Often, you spoke angrily or raised your voice.	◯	◯	◯	◯
You told [sname] that he/she is going to be spanked.	◯	◯	◯	◯
You gave [sname] a spanking, pop, or slap.	◯	◯	◯	◯
You told [sname] something like "You are a bad boy" or "You are a naughty girl."	◯	◯	◯	◯

The next questions ask about your relationship with [sname].

	Definitely NOT	Not Really	Not sure	Somewhat	Definitely
[sname] and I always seem to be struggling with each other.	◯	◯	◯	◯	◯

If upset, [sname] seeks comfort from me.	◯	◯	◯	◯	◯
[sname] gets angry at me easily.	◯	◯	◯	◯	◯
[sname] is usually happy to see me.	◯	◯	◯	◯	◯
It's easy to be in tune with what [sname] is saying.	◯	◯	◯	◯	◯
[sname] stays angry or resists me after I get upset with them.	◯	◯	◯	◯	◯
Dealing with [sname] drains my energy.	◯	◯	◯	◯	◯
When [sname] is in a bad mood, I know we're in for a long, hard day.	◯	◯	◯	◯	◯
[sname_my_poss_cap] feelings toward me can change suddenly or catch me off guard.	◯	◯	◯	◯	◯
Even though I've tried hard, I don't feel good about how we get along.	◯	◯	◯	◯	◯
[sname] gets upset when I leave the room.	◯	◯	◯	◯	◯
[sname] likes to be held by me.	◯	◯	◯	◯	◯
Dealing with [sname] makes me feel good about how I handle things.	◯	◯	◯	◯	◯

We would like to know what things you and [sname] do together. We know that you and other people who take care of [sname] have a lot to do! You may only do one or two of these things, or you may not have time to do any of them. There may be other important people in [snameposs] life who help you (like [snameposs] other parent, [snameposs] brother or sister, aunts or uncles, grandmothers or grandfathers, or babysitter). For this survey, please answer the questions about the things YOU do with [sname], NOT what those other people are doing with [sname]. Let's begin with some questions about books and reading!

Do you ever read baby or children's books to [sname] or is [sname] too young for that?

◯ Yes, we read books together
◯ No, [sname] is too young to read books together
◯ No, other reason

Think about 1 or 2 books that you have at home right now. About how many children's books in total do you have at home that you read to [sname]? We want to know about all the books in your home that you read to [sname]. This includes books that belong only to [sname] (not brothers or sisters) and books from the library that you read to [sname].

◯ None right now
◯ A few (1-5)
◯ Some (6-9)
◯ A medium amount (10-14)
◯ Quite a number (15-24)
◯ Many (25-49)
◯ Very many (50+)

	Not reading right now	Sometimes (1-2 days in a week)	Most days (3-4 days in a week)	Almost every day (5 or more days in a week)
How many days each week do you read children's books to [sname]?	◯	◯	◯	◯
Do you read a book to [sname] at bedtime, before putting him/her to sleep for the night?	◯	◯	◯	◯
Do you read books together with [sname] during the daytime (NOT at bedtime)?	◯	◯	◯	◯

For each of the following questions, try to remember specific times in which you did these activities with [sname]. Many parents are only able to do a couple of these activities. It is okay to say "Never" if you have not done this reading activity with [sname] yet or "once in a while," if you can only remember doing the activity 1 or 2 times ever.

While you read books to [sname], how often do you point to pictures and name them or talk about them to [sname]?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most of the time
◯ Almost always

Because you had said that you point to pictures in books and talk about them, could you please give an example of a book or time where you did this?

How often do you ask [sname] questions about the pictures or stories in books and try to have them talk about the story with you using questions like 'What is that called?' or 'What color is it?' Even if [sname] is not talking yet.

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most of the time
◯ Almost always

How often do you talk to [sname] about how the people or animals in the story are feeling?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most of the time
◯ Almost always

How often do you show [sname] the pictures and the printed words for that picture together, when you read with [sname]?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most of the time
◯ Almost always

In general, how has the COVID pandemic affected how much you read with [sname]?

◯ Read a lot more
◯ Read a little more
◯ Read a little less
◯ Read a lot less
◯ Did not affect how much I read with my child
◯ I do not want to answer

The next questions are about things that you may show [sname] If you think [sname] is TOO YOUNG to do something, please pick the word 'Never.' If [sname] is TOO OLD to still do some of these things, you may answer how often you used to do these things when [sname] was younger. If you pick 'Sometimes,' 'Most days,' or 'Almost everyday,' please make sure to answer the second part of the questions with your own words.

How often do you teach [sname] letters by using pictures of letters or toys?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How do you do this? (Choose one or more of these)

☐ Singing the alphabet song
☐ Using alphabet blocks
☐ Using magnet letters
☐ Using letters from a foam mat
☐ Using a poster or a banner
☐ Other

How often do you teach [sname] counting, or how to read numbers?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How do you do this? (Choose one or more of these)

☐ Counting fingers and/or toes
☐ Using blocks with numbers
☐ Counting the number of toys/clothes/items
☐ Using magnetic numbers
☐ Using numbers from a foam mat
☐ Using a poster or a banner
☐ Another way

How often do you teach [sname] colors?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

What are some colors that you have taught [sname]? (Choose one or more of these)

☐ Red
☐ Orange
☐ Yellow
☐ Green
☐ Blue
☐ Purple
☐ Pink
☐ Black
☐ White
☐ Brown

How often do you teach [sname] shapes?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How do you teach [sname] shapes? By: (Choose one or more of these)

☐ Naming shapes of things we see around
☐ Using books/workbooks
☐ Using flashcards
☐ Drawing shapes on paper
☐ Using toys
☐ Another way

How often do you teach [sname] about sizes?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How do you teach [sname] sizes? By: (Choose one or more of these)

☐ Telling [sname] different sizes
☐ Using household items
☐ Using foods as examples
☐ Using toys
☐ Another way

How often do you teach [sname] body parts using a doll, your body, or [snameposs] body?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How do you teach [sname] different body parts? (Choose one or more of these)

☐ Singing a song
☐ Using my face/body
☐ Using [sname_poss] own face/body
☐ Using a doll or stuffed animal
☐ Using an image/picture
☐ Another way

How often do you have [sname] look at letters and teach or explain the sound of those letters when you read or play with toys together?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

In general, how has the COVID pandemic affected how much you teach to [sname]?

◯ Teach a lot more
◯ Teach a little more
◯ Teach a little less
◯ Teach a lot less
◯ Did not affect how much I teach [sname]
◯ I do not want to answer

The next questions are about things that you may say or talk about with [sname]. If you think [sname] is TOO YOUNG to do something, please pick the word 'Never.' If [sname] is TOO OLD to still do some of these things, you may answer how often you used to do these things when [sname] was younger. If you pick 'Sometimes,' 'Most days,' or 'Almost everyday,' please answer the second part of the questions with your own words.

Some caregivers talk to their children about the things around them and what is happening around them. Have you started to talk to [sname] in this way?

◯ Yes
◯ No

About how many days each week do you do this?

◯ Sometimes (1-2 days in a week)
◯ Most days (3-4 days in a week)
◯ Almost every day (5 or more days in a week)

How often do you tell [sname] stories, such as folktales, stories that you made up, or stories about things that you have done together (without using a book)?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

What kinds of stories do you tell [sname]?

How often do you sing lullabies or other children's songs to [sname]?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

When do you sing to [sname]? (Choose one or more of these)

☐ At bedtime (night)
☐ During naptimes (day)
☐ Daytime

When [sname] is playing with toys, how often do you play along with him or her?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How often do you play make believe or pretend with [sname]?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

What do you and [sname] do during play pretend? (Choose one or more of these)

☐ Pretend to complete daily activities (for example: grocery shopping, household chores like cooking and cleaning, going to a school or to a job)
☐ Pretend we are different people (for example: Superheroes, Teacher/Student, Mommy/Baby)
☐ Use action figures or dolls as different characters
☐ We pretend play in some other way
☐ I mostly watch while [sname] plays

In general, how has the COVID pandemic affected how much you talk to [sname]?

◯ Talk a lot more
◯ Talk a little more
◯ Talk a little less
◯ Talk a lot less
◯ Did not affect how much I talk to [sname]
◯ I do not want to answer

We would like to know what things you and [sname] do together. We know that you and other people who take care of [sname] have a lot to do! You may only do one or two of these things, or you may not have time to do any of them. There may be other important people in [snameposs] life who help you (like [snameposs] other parent, [snameposs] brother or sister, aunts or uncles, grandmothers or grandfathers, or babysitter). For this survey, please answer the questions about the things YOU do with [sname], NOT what those other people are doing with [sname].

Let's begin with some questions about books and reading!

Do you ever read children's books to [sname] or is [sname] too young for that?

◯ Yes, we read books together
◯ No, [sname] is too young to read books together
◯ No, other reason

About how many books in total for preschool-aged children do you have at home, that you read aloud to [sname]? We would want you to include only books that belong only to [sname] (not brothers or sisters), or books from the library or school that you have at home right now that you read to [sname].

◯ None right now
◯ A few (1-5)
◯ Some (6-9)
◯ A medium amount (10-14)
◯ Quite a number (15-24)
◯ Many (25-49)
◯ Very many (50+)

How many days each week do you read children's books to [sname]?

◯ Not reading right now
◯ Sometimes (1-2 days in a week)
◯ Most days (3-4 days in a week)
◯ Almost every day (5 or more days in a week)

Do you ask [sname] to tell you about what happened in a story that you have read together?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most of the time
◯ Almost always

Because you said that you ask [sname] to tell you about what happened in a story you read together, could you please give an example of a book or time where you did this?

Do you match pictures with written words while you read with [sname]?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most of the time
◯ Almost always

How often do you talk to [sname] about feelings and emotions of characters in books?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most of the time
◯ Almost always

In general, how has the COVID pandemic affected how much you read with [sname]?

◯ Read a lot more
◯ Read a little more
◯ Read a little less
◯ Read a lot less
◯ Did not affect how much I read with [sname]
◯ I do not want to answer

The next questions are about activities that you help your child do, or that you do together.

Do you teach your child to tell time?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How do you do this? (Choose one or more of these)

☐ We look at the clock(s) in our home together
☐ We use a toy clock
☐ I tell [sname] what time it is
☐ I tell [sname] when it is time to do something (for example eat dinner, go to school)

How often do you teach [sname] to write letters of the alphabet?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How do you do this? (Choose one or more of these)

☐ I help [sname] trace letters
☐ [sname] practices writing letters on their own
☐ I have [sname] connect dots to make letters
☐ We work on activity books together
☐ I help [sname] make letters with other materials (for example sand, clay, paint)

How often do you teach [sname] to write their name or other words?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How often do you teach [sname] to add, such as "1 + 1" or "1 apple + 1 apple"?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How do you do this? (Choose one or more of these)

☐ [sname] learns about simple addition on their own (for example using a game or app)
☐ I talk with [sname] about more and less
☐ We use blocks, coins, or other objects to practice adding
☐ We practice using flashcards
☐ I help [sname] complete written addition problems

How often do you teach [sname] to recognize shapes?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How do you do this? (Choose one or more of these)

☐ We draw shapes together on paper
☐ [sname] learns about shapes on their own (for example using a game or app)
☐ We look at shapes in books
☐ We practice shapes using flashcards
☐ We use toy shapes

In general, how has the COVID pandemic affected how much you teach to your child?

◯ Teach a lot more
◯ Teach a little more
◯ Teach a little less
◯ Teach a lot less
◯ Did not affect how much I teach [sname]
◯ I do not want to answer

Next, let's talk about pretend play!

How often do you play make believe or pretend together with [sname]?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

What do you and [sname] do during pretend play? (Choose one or more of these)

☐ Pretend to complete daily activities (for example: grocery shopping, household chores like cooking and cleaning, going to school or to a job)
☐ Pretend we are different people (for example: superheroes, teacher/student, mommy/baby)
☐ Use action figures or dolls as pretend characters
☐ I mostly watch as [sname] plays

Do you encourage [sname] to write during pretend play (for example letters, words, shopping lists, menus)? Please answer about either real or pretend letters/words (for example wavy lines, pretend cursive).

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

What kinds of things does [sname] write or create? (Choose one or more of these)

☐ [sname] writes the alphabet letters or some words
☐ [sname] writes pretend shopping lists
☐ [sname] writes pretend recipes or menus
☐ [sname] writes pretend invitations
☐ [sname] writes other things using letters or words

How often do you talk to [sname] about feeling and emotions of characters during pretend play?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most of the time
◯ Almost always

Because you said that you talk about feelings of characters during pretend play, could you please give an example of a time where you did this?

The next questions are about games that you play with [sname]. If you play electronic versions (such as online versions or apps) of these games, the two of you must play it TOGETHER, just like the real physical game is played.

How often do you play games that have a set of rules with [sname]?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

What types of games with rules do you play with [sname]? (Choose one or more of these)

☐ Simple board games (for example: Candyland, Chutes and Ladders)
☐ Simple card games (for example: Uno, Go Fish)
☐ Games with rules about moving (for example: Red Light Green Light, Simon Says, Hide-and-seek)
☐ Games in which we need to be very careful because the pieces might break, fall, or make noise (for example: Jenga, Don't Break the Ice)
☐ [sname] plays games by themselves or with siblings, friends, or other children

In general, how has the COVID pandemic affected how much you play with [sname]?

◯ Play a lot more
◯ Play a little more
◯ Play a little less
◯ Play a lot less
◯ Did not affect how much I play with [sname]
◯ I do not want to answer

The next questions are about things you may say or talk about with your child.

How often do you talk to [sname] about [snameposs] own feelings and emotions?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

Because you said that you talk about feelings with [sname], could you please give an example of a time where you did this?

How often do you ask [sname] to tell you about what [sname] did in [snameposs] day?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How often do you and [sname] talk together to make plans for activities that you will be doing together either in your home (for example, cooking, doing a project together) or outside your home (for example going to the store or park)?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

Because you said that you talk about making plans with [sname], could you please give an example of a time where you did this?

In general, how has the COVID pandemic affected how much you talk to [sname]?

◯ Talk a lot more
◯ Talk a little more
◯ Talk a little less
◯ Talk a lot less
◯ Did not affect how much I talk to [sname]
◯ I do not want to answer

We would like to know what things you and [sname] do together. We know that you and other people who take care of [sname] have a lot to do! You may only do one or two of these things, or you may not have time to do any of them. There may be other important people in [snameposs] life who help you (like [snameposs] other parent, [snameposs] brother or sister, aunts or uncles, grandmothers or grandfathers, or babysitter). For this survey, please answer the questions about the things YOU do with [sname], NOT what those other people are doing with [sname].

Let's begin with some questions about books and reading!

About how many books in total for elementary school-aged children do you have at home, that you read aloud to [sname] or you have [sname] read aloud to you? We would want you to include only books that belong only to [sname] (not brothers or sisters), books from the library or school that you have at home right now, that you read to [sname].

◯ None right now
◯ A few (1-5)
◯ Some (6-9)
◯ A medium amount (10-14)
◯ Quite a number (15-24)
◯ Many (25-49)
◯ Very many (50+)

How many days during a typical week does your child read or look at books alone at home (not related to school work)?

◯ [sname] doesn't read alone right now
◯ Sometimes (1 - 2 days in a week)
◯ Most days (3 - 4 days in a week)
◯ Almost every day (5 or more days in a week)

Do you ever read children's books together with [sname] or is [sname] too old for that?

◯ Yes, we read books together
◯ No, [sname] is too old to read books together
◯ No, other reason

How many days each week do you read children's books to [sname]?

◯ Not reading right now
◯ Sometimes (1 - 2 days in a week)
◯ Most days (3 - 4 days in a week)
◯ Almost every day (5 or more days in a week)

How many days each week do you encourage or ask [sname] to read aloud to you?

◯ Not reading right now
◯ Sometimes (1 - 2 days in a week)
◯ Most days (3 - 4 days in a week)
◯ Almost every day (5 or more days in a week)

How often do you ask [sname] to tell you about what happened in a story that you read together?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most of the time
◯ Almost Always

How often do you talk to [sname] about feelings and emotions of characters in books?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most of the time
◯ Almost Always

In general, how has the COVID pandemic affected how much you read with [sname]?

◯ Read a lot more
◯ Read a little more
◯ Read a little less
◯ Read a lot less
◯ Did not affect how much I read with [sname]
◯ I do not want to answer

Next, let's talk about pretend play!

How often do you play make believe or pretend with [sname]?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

What do you and [sname] do during play pretend? (Choose one or more of these)

☐ Pretend to complete daily activities (for example: grocery shopping, household chores like cooking and cleaning, going to a school or to a job)
☐ Pretend we are different people (for example: Superheroes, Teacher/Student, Mommy/Baby)
☐ Use action figures or dolls as different characters
☐ We pretend play in some other way
☐ I mostly watch while [sname] plays

How often does [sname] write using letters or words during play (for example, shopping lists, menus, stories)? Please answer about either real or pretend letters/words)

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How often do you talk to [sname] about feelings and emotions of characters during pretend play?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most of the time
◯ Almost Always

The next questions are about games that you play with [sname]. If you play electronic versions (such as online versions or apps) of these games, the two of you must play it TOGETHER, just like the real physical game is played.

How often do you play games that have a set of rules with [sname]?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

What types of games with rules do you play with [sname]? (Choose one or more of these)

◯ Board games (for example: Sorry, Chutes and Ladders)
◯ Card games (for example: Uno, Go-Fish)
◯ Games in which we act out a character and the other person has to guess (Example: Charades)
◯ Games in which we make words or stories (for example: Scrabble Jr., Boggle Jr.)
◯ Games in which we ask trivia questions or take turns answering questions about different topics (Example: Cranium, Trivial Pursuit Jr.)
◯ Games in which we need to be very careful because the pieces might break, fall, or make noise (for example: Jenga, Perfection, Operation)

In general, how has the COVID pandemic affected how much you play with [sname]?

◯ Play a lot more
◯ Play a little more
◯ Play a little less
◯ Play a lot less
◯ Did not affect how much I play with my child
◯ I do not want to answer

The next questions are about things you may say or talk about with [sname].

How often do you talk to [sname] about [snameposs] own feelings and emotions?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How often do you ask [sname] to tell you about what they did in their day?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How often do you and [sname] talk together to make plans activities that you will be doing together either in your home (for example, cooking, doing a project together) or outside your home (for example, going to the store or park)?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

In general, how has the COVID pandemic affected how much you talk to [sname]?

◯ Talk a lot more
◯ Talk a little more
◯ Talk a little less
◯ Talk a lot less
◯ Did not affect how much I talk to [sname]
◯ I do not want to answer

The next questions are about activities that you help [sname] do, or that you do together.

How often do you help [sname] build with toys like blocks, magnet tiles, Lincoln logs, or Legos.

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How often do you do art projects with [sname], like coloring, drawing, painting, making something with clay, beads, or popsicle sticks?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How often do you do science projects, like with magnets, a chemistry project (like a baking soda volcano), space or astronomy, fossils, archeology, plants, living creatures like insects, butterflies or birds, with [sname]?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

How often do you help [sname] with [snameposs] homework?

◯ Never
◯ Once in a while
◯ Sometimes
◯ Most days
◯ Almost everyday

In general, how has the COVID pandemic affected how much you do these activities with [sname]?

◯ Do these activities a lot more
◯ Do these activities a little more
◯ Do these activities a little less
◯ Do these activities a lot less
◯ Did not affect how much I do these activites with [sname]
◯ I do not want to answer

COVID Symptoms

ERROR! You must complete the visit form before you can start this form.

Date PASC Symptoms survey collected:

_____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

We are now going to ask about symptoms that [sname_you] might be having.

[ps_stext_2_4_wk], did [sname_you] have any of these problems or symptoms?

General symptoms or problems:

	Yes	No	I don't know
Fever	◯	◯	◯
Feeling sleepy during the day time	◯	◯	◯
Trouble sleeping	◯	◯	◯
Fussy or cranky (crying a lot)	◯	◯	◯
Low energy or not feeling strong enough to do things	◯	◯	◯
Feeling very tired all day long	◯	◯	◯
Feeling very tired after walking	◯	◯	◯
Sweating more than normal	◯	◯	◯
Hot and cold spells (feeling hot or cold for no reason)	◯	◯	◯
Not wanting to eat (poor appetite)	◯	◯	◯
Wanting to eat more than normal (increased appetite)	◯	◯	◯
Wanting to drink liquids more than normal (increased thirst)	◯	◯	◯
Lost weight or gained less than expected	◯	◯	◯
Gained weight more than expected	◯	◯	◯
Lost height or grew less than expected	◯	◯	◯

Symptoms or problems in the eyes, ears, nose, and throat:

	Yes	No	I don't know

Eyes look red	◯	◯	◯
Eyes are watery	◯	◯	◯
Eyes are dry	◯	◯	◯
Dark circles or color under the eyes	◯	◯	◯
Trouble seeing or blurry vision	◯	◯	◯
Light hurts your eyes	◯	◯	◯
Change in hearing	◯	◯	◯
Ringing in the ears	◯	◯	◯
Stuffy nose or runny nose	◯	◯	◯
Change in smell	◯	◯	◯
Loss of smell	◯	◯	◯
Very dry mouth	◯	◯	◯
Throat hurts (sore throat)	◯	◯	◯
Loss of voice (sounding hoarse)	◯	◯	◯
Problems swallowing	◯	◯	◯
Change in how things taste	◯	◯	◯
Problems with teeth or gums	◯	◯	◯
Chapped lips	◯	◯	◯

Symptoms or problems involving the heart and lungs:

	Yes	No	I don't know
Dry cough	◯	◯	◯
Wet cough (brings up mucus)	◯	◯	◯
Barking cough	◯	◯	◯
Trouble breathing (breathing too fast)	◯	◯	◯
Pain when breathing	◯	◯	◯
Pain in the chest	◯	◯	◯
Feeling like your heart is beating really fast, racing, or pounding (called palpitations) when not doing exercise	◯	◯	◯
Feeling like your heart is beating really fast when doing exercise	◯	◯	◯
Fainting or feeling like you are going to faint (lightheaded)	◯	◯	◯
Trouble walking	◯	◯	◯
Trouble climbing stairs	◯	◯	◯
Trouble running	◯	◯	◯

Symptoms or problems involving the belly:

	Yes	No	I don't know
Stomach pains/cramps	◯	◯	◯
Nausea (feeling like you are going to throw up)	◯	◯	◯
Throwing up (vomiting)	◯	◯	◯
Loose stool (diarrhea)	◯	◯	◯
Trouble pooping/stooling (constipation)	◯	◯	◯
Pain with peeing (urination)	◯	◯	◯
Peeing more than normal (urination more than normal)	◯	◯	◯

Symptoms or problems involving the skin, hair, and nails:

	Yes	No	I don't know
Skin rash	◯	◯	◯
Itchiness of the skin	◯	◯	◯
Changes or problems with nails	◯	◯	◯
Changes or problems with hair	◯	◯	◯
Color changes in your skin, such as red, white or purple	◯	◯	◯
Color changes on the fingers or toes	◯	◯	◯

Symptoms or problems involving the bones and muscles:

	Yes	No	I don't know
Muscle weakness	◯	◯	◯
Sore muscles or pain in the muscles	◯	◯	◯
Body aches or pains	◯	◯	◯
Pains in the joints (like the elbows, knees, ankles)	◯	◯	◯
Pain in the back	◯	◯	◯
Pain in the neck	◯	◯	◯

Symptoms or problems involving the brain and nerves:

	Yes	No	I don't know
Headache	◯	◯	◯
Feeling dizzy (feeling like the room is spinning)	◯	◯	◯
Shakiness or tremors	◯	◯	◯

Feeling tingling or 'pin-and-needles' in the hands and feet	○	○	○
Unable to move part of the body	○	○	○
Problems with remembering things (memory)	○	○	○
Problems with focusing on things (concentration), sometimes called "brain fog"	○	○	○
Problems with talking	○	○	○

Symptoms or problems involving feelings or behavior:

	Yes	No	I don't know
Feeling sad or depressed	○	○	○
Feeling anxious or on edge	○	○	○
Feeling a lot of fear when being away from parent or caregiver	○	○	○
Feeling a lot of fear of specific things like spiders or being up high	○	○	○
Feeling a lot of fear about being with other children or adults	○	○	○
Feeling fear of crowds or being in closed-in spaces	○	○	○
Having a sudden intense feeling of fear, like a panic attack	○	○	○
Refusing to go to school	○	○	○
Having a lot of tantrums	○	○	○
Holding their breath for a long time when they are afraid or angry	○	○	○
Having nightmares	○	○	○
Screaming in fear while asleep, sometimes called night terrors	○	○	○
Seeing, hearing, or feeling that something is there when it is not (hallucinations)	○	○	○
Aggressive behavior like hitting, biting or kicking	○	○	○
Rocking the body back and forth or head banging	○	○	○

Being hyperactive or much more active than other children	◯	◯	◯
Refusing to follow rules or doing what they are asked to do	◯	◯	◯
Serious breaking of rules like lying, stealing, starting fights, or bullying	◯	◯	◯
Having repeating memories, dreams, thoughts, or worries after a traumatic event	◯	◯	◯

Symptoms or problems involving periods:

	Yes	No	I don't know
Getting periods less often	◯	◯	◯
Getting periods more often	◯	◯	◯
Heavier periods	◯	◯	◯
Lighter periods	◯	◯	◯

[ps_stext_8_wk], [sv_has] [sname_you] had any of these problems or symptoms for longer than 4 weeks? These are problems or symptoms that kept happening without stopping or kept happening again and again for longer than 4 weeks.

General symptoms or problems:

	No, [sname_i] did not have them	No, [sname_i] had them for less than 4 weeks	Yes, [sname_i] had them for 4 weeks or more	I don't know
Fever	◯	◯	◯	◯
Feeling sleepy during the day time	◯	◯	◯	◯
Trouble sleeping	◯	◯	◯	◯
Fussy or cranky (crying a lot)	◯	◯	◯	◯
Low energy or not feeling strong enough to do things	◯	◯	◯	◯
Feeling very tired all day long	◯	◯	◯	◯
Feeling very tired after walking	◯	◯	◯	◯
Sweating more than normal	◯	◯	◯	◯
Hot and cold spells (feeling hot or cold for no reason)	◯	◯	◯	◯
Not wanting to eat (poor appetite)	◯	◯	◯	◯
Wanting to eat more than normal (increased appetite)	◯	◯	◯	◯

Wanting to drink liquids more than normal (increased thirst)	◯	◯	◯	◯
Lost weight or gained less than expected	◯	◯	◯	◯
Gained weight more than expected	◯	◯	◯	◯
Lost height or grew less than expected	◯	◯	◯	◯

Symptoms or problems in the eyes, ears, nose, and throat:

	No, [sname_i] did not have them	No, [sname_i] had them for less than 4 weeks	Yes, [sname_i] had them for 4 weeks or more	I don't know
Eyes look red	◯	◯	◯	◯
Eyes are watery	◯	◯	◯	◯
Eyes are dry	◯	◯	◯	◯
Dark circles or color under the eyes	◯	◯	◯	◯
Trouble seeing or blurry vision	◯	◯	◯	◯
Light hurts your eyes	◯	◯	◯	◯
Change in hearing	◯	◯	◯	◯
Ringing in the ears	◯	◯	◯	◯
Stuffy nose or runny nose	◯	◯	◯	◯
Change in smell	◯	◯	◯	◯
Loss of smell	◯	◯	◯	◯
Very dry mouth	◯	◯	◯	◯
Throat hurts (sore throat)	◯	◯	◯	◯
Loss of voice (sounding hoarse)	◯	◯	◯	◯
Problems swallowing	◯	◯	◯	◯
Change in how things taste	◯	◯	◯	◯
Problems with teeth or gums	◯	◯	◯	◯
Chapped lips	◯	◯	◯	◯

Symptoms or problems involving the heart and lungs:

	No, [sname_i] did not have them	No, [sname_i] had them for less than 4 weeks	Yes, [sname_i] had them for 4 weeks or more	I don't know
Dry cough	◯	◯	◯	◯
Wet cough (brings up mucus)	◯	◯	◯	◯
Barking cough	◯	◯	◯	◯

Trouble breathing (breathing too fast)	○	○	○	○
Pain when breathing	○	○	○	○
Pain in the chest	○	○	○	○
Feeling like your heart is beating really fast, racing, or pounding (called palpitations) when not doing exercise	○	○	○	○
Feeling like your heart is beating really fast when doing exercise	○	○	○	○
Fainting or feeling like you are going to faint (lightheaded)	○	○	○	○
Trouble walking	○	○	○	○
Trouble climbing stairs	○	○	○	○
Trouble running	○	○	○	○

Symptoms or problems involving the belly:

	No, [sname_i] did not have them	No, [sname_i] had them for less than 4 weeks	Yes, [sname_i] had them for 4 weeks or more	I don't know
Stomach pains/cramps	○	○	○	○
Nausea (feeling like you are going to throw up)	○	○	○	○
Throwing up (vomiting)	○	○	○	○
Loose stool (diarrhea)	○	○	○	○
Trouble pooping/stooling (constipation)	○	○	○	○
Pain with peeing (urination)	○	○	○	○
Peeing more than normal (urination more than normal)	○	○	○	○

Symptoms or problems involving the skin, hair, and nails:

	No, [sname_i] did not have them	No, [sname_i] had them for less than 4 weeks	Yes, [sname_i] had them for 4 weeks or more	I don't know
Skin rash	○	○	○	○
Itchiness of the skin	○	○	○	○
Changes or problems with nails	○	○	○	○
Changes or problems with hair	○	○	○	○
Color changes in your skin, such as red, white or purple	○	○	○	○

Color changes on the fingers or toes	◯	◯	◯	◯

Symptoms or problems involving the bones and muscles:

	No, [sname_i] did not have them	No, [sname_i] had them for less than 4 weeks	Yes, [sname_i] had them for 4 weeks or more	I don't know
Muscle weakness	◯	◯	◯	◯
Sore muscles or pain in the muscles	◯	◯	◯	◯
Body aches or pains	◯	◯	◯	◯
Pains in the joints (like the elbows, knees, ankles)	◯	◯	◯	◯
Pain in the back	◯	◯	◯	◯
Pain in the neck	◯	◯	◯	◯

Symptoms or problems involving the brain and nerves:

	No, [sname_i] did not have them	No, [sname_i] had them for less than 4 weeks	Yes, [sname_i] had them for 4 weeks or more	I don't know
Headache	◯	◯	◯	◯
Feeling dizzy (feeling like the room is spinning)	◯	◯	◯	◯
Shakiness or tremors	◯	◯	◯	◯
Feeling tingling or 'pin-and-needles' in the hands and feet	◯	◯	◯	◯
Unable to move part of the body	◯	◯	◯	◯
Problems with remembering things (memory)	◯	◯	◯	◯
Problems with focusing on things (concentration), sometimes called "brain fog"	◯	◯	◯	◯
Problems with talking	◯	◯	◯	◯

Symptoms or problems involving feelings or behavior:

	No, [sname_i] did not have them	No, [sname_i] had them for less than 4 weeks	Yes, [sname_i] had them for 4 weeks or more	I don't know
Feeling sad or depressed	◯	◯	◯	◯
Feeling anxious or on edge	◯	◯	◯	◯

Feeling a lot of fear when being away from parent or caregiver	○	○	○	○
Feeling a lot of fear of specific things like spiders or being up high	○	○	○	○
Feeling a lot of fear about being with other children or adults	○	○	○	○
Feeling fear of crowds or being in closed-in spaces	○	○	○	○
Having a sudden intense feeling of fear, like a panic attack	○	○	○	○
Refusing to go to school	○	○	○	○
Having a lot of tantrums	○	○	○	○
Holding their breath for a long time when they are afraid or angry	○	○	○	○
Having nightmares	○	○	○	○
Screaming in fear while asleep, sometimes called night terrors	○	○	○	○
Seeing, hearing, or feeling that something is there when it is not (hallucinations)	○	○	○	○
Aggressive behavior like hitting, biting or kicking	○	○	○	○
Rocking the body back and forth or head banging	○	○	○	○
Being hyperactive or much more active than other children	○	○	○	○
Refusing to follow rules or doing what they are asked to do	○	○	○	○
Serious breaking of rules like lying, stealing, starting fights, or bullying	○	○	○	○
Having repeating memories, dreams, thoughts, or worries after a traumatic event	○	○	○	○

Symptoms or problems involving periods:

	No, [sname_i] did not have them	No, [sname_i] had them for less than 4 weeks	Yes, [sname_i] had them for 4 weeks or more	I don't know
Getting periods less often	○	○	○	○

Getting periods more often	◯	◯	◯	◯
Heavier periods	◯	◯	◯	◯
Lighter periods	◯	◯	◯	◯

Now, we are going to ask about any problems or symptoms that [sname_you] had. First, we want to know about the problems or symptoms that kept happening for more than four weeks since the pandemic began.

Did [sname_you] have any of these problems or symptoms lasting for more than 4 weeks that started or got worse since the COVID pandemic began in March 2020? These are problems or symptoms that kept happening without stopping or kept happening again and again for longer than 4 weeks.

General symptoms or problems:

	No	Yes and it started before [sname_my_poss] COVID infection	Yes and it started during or after [sname_my_poss] COVID infection	I don't know
Fever	◯	◯	◯	◯
Feeling sleepy during the day time	◯	◯	◯	◯
Trouble sleeping	◯	◯	◯	◯
Fussy or cranky (crying a lot)	◯	◯	◯	◯
Low energy or not feeling strong enough to do things	◯	◯	◯	◯
Feeling very tired all day long	◯	◯	◯	◯
Feeling very tired after walking	◯	◯	◯	◯
Sweating more than normal	◯	◯	◯	◯
Hot and cold spells (feeling hot or cold for no reason)	◯	◯	◯	◯
Not wanting to eat (poor appetite)	◯	◯	◯	◯
Wanting to eat more than normal (increased appetite)	◯	◯	◯	◯
Wanting to drink liquids more than normal (increased thirst)	◯	◯	◯	◯
Lost weight or gained less than expected	◯	◯	◯	◯
Gained weight more than expected	◯	◯	◯	◯
Lost height or grew less than expected	◯	◯	◯	◯

Symptoms or problems in the eyes, ears, nose, and throat:

	No	Yes and it started before [sname_my_poss] COVID infection	Yes and it started during or after [sname_my_poss] COVID infection	I don't know
Eyes look red	○	○	○	○
Eyes are watery	○	○	○	○
Eyes are dry	○	○	○	○
Dark circles or color under the eyes	○	○	○	○
Trouble seeing or blurry vision	○	○	○	○
Light hurts your eyes	○	○	○	○
Change in hearing	○	○	○	○
Ringing in the ears	○	○	○	○
Stuffy nose or runny nose	○	○	○	○
Change in smell	○	○	○	○
Loss of smell	○	○	○	○
Very dry mouth	○	○	○	○
Throat hurts (sore throat)	○	○	○	○
Loss of voice (sounding hoarse)	○	○	○	○
Problems swallowing	○	○	○	○
Change in how things taste	○	○	○	○
Problems with teeth or gums	○	○	○	○
Chapped lips	○	○	○	○

Symptoms or problems involving the heart and lungs:

	No	Yes and it started before [sname_my_poss] COVID infection	Yes and it started during or after [sname_my_poss] COVID infection	I don't know
Dry cough	○	○	○	○
Wet cough (brings up mucus)	○	○	○	○
Barking cough	○	○	○	○
Trouble breathing (breathing too fast)	○	○	○	○
Pain when breathing	○	○	○	○
Pain in the chest	○	○	○	○
Feeling like your heart is beating really fast, racing, or pounding (called palpitations) when not doing exercise	○	○	○	○
Feeling like your heart is beating really fast when doing exercise	○	○	○	○

Fainting or feeling like you are going to faint (lightheaded)	○	○	○	○
Trouble walking	○	○	○	○
Trouble climbing stairs	○	○	○	○
Trouble running	○	○	○	○

Symptoms or problems involving the belly:

	No	Yes and it started before [sname_my_poss] COVID infection	Yes and it started during or after [sname_my_poss] COVID infection	I don't know
Stomach pains/cramps	○	○	○	○
Nausea (feeling like you are going to throw up)	○	○	○	○
Throwing up (vomiting)	○	○	○	○
Loose stool (diarrhea)	○	○	○	○
Trouble pooping/stooling (constipation)	○	○	○	○
Pain with peeing (urination)	○	○	○	○
Peeing more than normal (urination more than normal)	○	○	○	○

Symptoms or problems involving the skin, hair, and nails:

	No	Yes and it started before [sname_my_poss] COVID infection	Yes and it started during or after [sname_my_poss] COVID infection	I don't know
Skin rash	○	○	○	○
Itchiness of the skin	○	○	○	○
Changes or problems with nails	○	○	○	○
Changes or problems with hair	○	○	○	○
Color changes in your skin, such as red, white or purple	○	○	○	○
Color changes on the fingers or toes	○	○	○	○

Symptoms or problems involving the bones and muscles:

	No	Yes and it started before [sname_my_poss] COVID infection	Yes and it started during or after [sname_my_poss] COVID infection	I don't know

Muscle weakness	○	○	○	○
Sore muscles or pain in the muscles	○	○	○	○
Body aches or pains	○	○	○	○
Pains in the joints (like the elbows, knees, ankles)	○	○	○	○
Pain in the back	○	○	○	○
Pain in the neck	○	○	○	○

Symptoms or problems involving the brain and nerves:

	No	Yes and it started before [sname_my_poss] COVID infection	Yes and it started during or after [sname_my_poss] COVID infection	I don't know
Headache	○	○	○	○
Feeling dizzy (feeling like the room is spinning)	○	○	○	○
Shakiness or tremors	○	○	○	○
Feeling tingling or 'pin-and-needles' in the hands and feet	○	○	○	○
Unable to move part of the body	○	○	○	○
Problems with remembering things (memory)	○	○	○	○
Problems with focusing on things (concentration), sometimes called "brain fog"	○	○	○	○
Problems with talking	○	○	○	○

Symptoms or problems involving feelings or behavior:

	No	Yes and it started before [sname_my_poss] COVID infection	Yes and it started during or after [sname_my_poss] COVID infection	I don't know
Feeling sad or depressed	○	○	○	○
Feeling anxious or on edge	○	○	○	○
Feeling a lot of fear when being away from parent or caregiver	○	○	○	○
Feeling a lot of fear of specific things like spiders or being up high	○	○	○	○

Feeling a lot of fear about being with other children or adults	○	○	○	○
Feeling fear of crowds or being in closed-in spaces	○	○	○	○
Having a sudden intense feeling of fear, like a panic attack	○	○	○	○
Refusing to go to school	○	○	○	○
Having a lot of tantrums	○	○	○	○
Holding their breath for a long time when they are afraid or angry	○	○	○	○
Having nightmares	○	○	○	○
Screaming in fear while asleep, sometimes called night terrors	○	○	○	○
Seeing, hearing, or feeling that something is there when it is not (hallucinations)	○	○	○	○
Aggressive behavior like hitting, biting or kicking	○	○	○	○
Rocking the body back and forth or head banging	○	○	○	○
Being hyperactive or much more active than other children	○	○	○	○
Refusing to follow rules or doing what they are asked to do	○	○	○	○
Serious breaking of rules like lying, stealing, starting fights, or bullying	○	○	○	○
Having repeating memories, dreams, thoughts, or worries after a traumatic event	○	○	○	○

Symptoms or problems involving periods:

	No	Yes and it started before [sname_my_poss] COVID infection	Yes and it started during or after [sname_my_poss] COVID infection	I don't know
Getting periods less often	○	○	○	○
Getting periods more often	○	○	○	○
Heavier periods	○	○	○	○
Lighter periods	○	○	○	○

Did [sname_you] have any of these problems or symptoms lasting for more than 4 weeks that started or got worse since the COVID pandemic began in March 2020? These are problems or symptoms that kept happening without stopping or kept happening again and again for longer than 4 weeks.

General symptoms or problems:

	Yes	No	I don't know
Fever	○	○	○
Feeling sleepy during the day time	○	○	○
Trouble sleeping	○	○	○
Fussy or cranky (crying a lot)	○	○	○
Low energy or not feeling strong enough to do things	○	○	○
Feeling very tired all day long	○	○	○
Feeling very tired after walking	○	○	○
Sweating more than normal	○	○	○
Hot and cold spells (feeling hot or cold for no reason)	○	○	○
Not wanting to eat (poor appetite)	○	○	○
Wanting to eat more than normal (increased appetite)	○	○	○
Wanting to drink liquids more than normal (increased thirst)	○	○	○
Lost weight or gained less than expected	○	○	○
Gained weight more than expected	○	○	○
Lost height or grew less than expected	○	○	○

Symptoms or problems in the eyes, ears, nose, and throat:

	Yes	No	I don't know
Eyes look red	○	○	○
Eyes are watery	○	○	○
Eyes are dry	○	○	○
Dark circles or color under the eyes	○	○	○
Trouble seeing or blurry vision	○	○	○
Light hurts your eyes	○	○	○
Change in hearing	○	○	○
Ringing in the ears	○	○	○
Stuffy nose or runny nose	○	○	○
Change in smell	○	○	○
Loss of smell	○	○	○
Very dry mouth	○	○	○
Throat hurts (sore throat)	○	○	○
Loss of voice (sounding hoarse)	○	○	○

Problems swallowing	◯	◯	◯
Change in how things taste	◯	◯	◯
Problems with teeth or gums	◯	◯	◯
Chapped lips	◯	◯	◯

Symptoms or problems involving the heart and lungs:

	Yes	No	I don't know
Dry cough	◯	◯	◯
Wet cough (brings up mucus)	◯	◯	◯
Barking cough	◯	◯	◯
Trouble breathing (breathing too fast)	◯	◯	◯
Pain when breathing	◯	◯	◯
Pain in the chest	◯	◯	◯
Feeling like your heart is beating really fast, racing, or pounding (called palpitations) when not doing exercise	◯	◯	◯
Feeling like your heart is beating really fast when doing exercise	◯	◯	◯
Fainting or feeling like you are going to faint (lightheaded)	◯	◯	◯
Trouble walking	◯	◯	◯
Trouble climbing stairs	◯	◯	◯
Trouble running	◯	◯	◯

Symptoms or problems involving the belly:

	Yes	No	I don't know
Stomach pains/cramps	◯	◯	◯
Nausea (feeling like you are going to throw up)	◯	◯	◯
Throwing up (vomiting)	◯	◯	◯
Loose stool (diarrhea)	◯	◯	◯
Trouble pooping/stooling (constipation)	◯	◯	◯
Pain with peeing (urination)	◯	◯	◯
Peeing more than normal (urination more than normal)	◯	◯	◯

Symptoms or problems involving the skin, hair, and nails:

	Yes	No	I don't know
Skin rash	○	○	○
Itchiness of the skin	○	○	○
Changes or problems with nails	○	○	○
Changes or problems with hair	○	○	○
Color changes in your skin, such as red, white or purple	○	○	○
Color changes on the fingers or toes	○	○	○

Symptoms or problems involving the bones and muscles:

	Yes	No	I don't know
Muscle weakness	○	○	○
Sore muscles or pain in the muscles	○	○	○
Body aches or pains	○	○	○
Pains in the joints (like the elbows, knees, ankles)	○	○	○
Pain in the back	○	○	○
Pain in the neck	○	○	○

Symptoms or problems involving the brain and nerves:

	Yes	No	I don't know
Headache	○	○	○
Feeling dizzy (feeling like the room is spinning)	○	○	○
Shakiness or tremors	○	○	○
Feeling tingling or 'pin-and-needles' in the hands and feet	○	○	○
Unable to move part of the body	○	○	○
Problems with remembering things (memory)	○	○	○
Problems with focusing on things (concentration), sometimes called "brain fog"	○	○	○
Problems with talking	○	○	○

Symptoms or problems involving feelings or behavior:

	Yes	No	I don't know
Feeling sad or depressed	○	○	○
Feeling anxious or on edge	○	○	○

Feeling a lot of fear when being away from parent or caregiver	○	○	○
Feeling a lot of fear of specific things like spiders or being up high	○	○	○
Feeling a lot of fear about being with other children or adults	○	○	○
Feeling fear of crowds or being in closed-in spaces	○	○	○
Having a sudden intense feeling of fear, like a panic attack	○	○	○
Refusing to go to school	○	○	○
Having a lot of tantrums	○	○	○
Holding their breath for a long time when they are afraid or angry	○	○	○
Having nightmares	○	○	○
Screaming in fear while asleep, sometimes called night terrors	○	○	○
Seeing, hearing, or feeling that something is there when it is not (hallucinations)	○	○	○
Aggressive behavior like hitting, biting or kicking	○	○	○
Rocking the body back and forth or head banging	○	○	○
Being hyperactive or much more active than other children	○	○	○
Refusing to follow rules or doing what they are asked to do	○	○	○
Serious breaking of rules like lying, stealing, starting fights, or bullying	○	○	○
Having repeating memories, dreams, thoughts, or worries after a traumatic event	○	○	○

Symptoms or problems involving periods:

	Yes	No	I don't know
Getting periods less often	○	○	○
Getting periods more often	○	○	○
Heavier periods	○	○	○

Lighter periods	◯	◯	◯

Now, we are going to ask about the problems or symptoms [sname_you] had when [sname_you] first got COVID.

When [sname_you] first got infected with COVID, did [sname_you] have any of these problems or symptoms in the first two weeks after getting COVID?

General symptoms or problems:

	Yes	No	I don't know
Fever	◯	◯	◯
Feeling sleepy during the day time	◯	◯	◯
Trouble sleeping	◯	◯	◯
Fussy or cranky (crying a lot)	◯	◯	◯
Low energy or not feeling strong enough to do things	◯	◯	◯
Feeling very tired all day long	◯	◯	◯
Feeling very tired after walking	◯	◯	◯
Sweating more than normal	◯	◯	◯
Hot and cold spells (feeling hot or cold for no reason)	◯	◯	◯
Not wanting to eat (poor appetite)	◯	◯	◯
Wanting to eat more than normal (increased appetite)	◯	◯	◯
Wanting to drink liquids more than normal (increased thirst)	◯	◯	◯
Lost weight or gained less than expected	◯	◯	◯
Gained weight more than expected	◯	◯	◯
Lost height or grew less than expected	◯	◯	◯

Symptoms or problems in the eyes, ears, nose, and throat:

	Yes	No	I don't know
Eyes look red	◯	◯	◯
Eyes are watery	◯	◯	◯
Eyes are dry	◯	◯	◯
Dark circles or color under the eyes	◯	◯	◯
Trouble seeing or blurry vision	◯	◯	◯
Light hurts your eyes	◯	◯	◯

Change in hearing	○	○	○
Ringing in the ears	○	○	○
Stuffy nose or runny nose	○	○	○
Change in smell	○	○	○
Loss of smell	○	○	○
Very dry mouth	○	○	○
Throat hurts (sore throat)	○	○	○
Loss of voice (sounding hoarse)	○	○	○
Problems swallowing	○	○	○
Change in how things taste	○	○	○
Problems with teeth or gums	○	○	○
Chapped lips	○	○	○

Symptoms or problems involving the heart and lungs:

	Yes	No	I don't know
Dry cough	○	○	○
Wet cough (brings up mucus)	○	○	○
Barking cough	○	○	○
Trouble breathing (breathing too fast)	○	○	○
Pain when breathing	○	○	○
Pain in the chest	○	○	○
Feeling like your heart is beating really fast, racing, or pounding (called palpitations) when not doing exercise	○	○	○
Feeling like your heart is beating really fast when doing exercise	○	○	○
Fainting or feeling like you are going to faint (lightheaded)	○	○	○
Trouble walking	○	○	○
Trouble climbing stairs	○	○	○
Trouble running	○	○	○

Symptoms or problems involving the belly:

	Yes	No	I don't know
Stomach pains/cramps	○	○	○
Nausea (feeling like you are going to throw up)	○	○	○

Throwing up (vomiting)	◯	◯	◯
Loose stool (diarrhea)	◯	◯	◯
Trouble pooping/stooling (constipation)	◯	◯	◯
Pain with peeing (urination)	◯	◯	◯
Peeing more than normal (urination more than normal)	◯	◯	◯

Symptoms or problems involving the skin, hair, and nails:

	Yes	No	I don't know
Skin rash	◯	◯	◯
Itchiness of the skin	◯	◯	◯
Changes or problems with nails	◯	◯	◯
Changes or problems with hair	◯	◯	◯
Color changes in your skin, such as red, white or purple	◯	◯	◯
Color changes on the fingers or toes	◯	◯	◯

Symptoms or problems involving the bones and muscles:

	Yes	No	I don't know
Muscle weakness	◯	◯	◯
Sore muscles or pain in the muscles	◯	◯	◯
Body aches or pains	◯	◯	◯
Pains in the joints (like the elbows, knees, ankles)	◯	◯	◯
Pain in the back	◯	◯	◯
Pain in the neck	◯	◯	◯

Symptoms or problems involving the brain and nerves:

	Yes	No	I don't know
Headache	◯	◯	◯
Feeling dizzy (feeling like the room is spinning)	◯	◯	◯
Shakiness or tremors	◯	◯	◯
Feeling tingling or 'pin-and-needles' in the hands and feet	◯	◯	◯
Unable to move part of the body	◯	◯	◯

Problems with remembering things (memory)	○	○	○
Problems with focusing on things (concentration), sometimes called "brain fog"	○	○	○
Problems with talking	○	○	○

Symptoms or problems involving feelings or behavior:

	Yes	No	I don't know
Feeling sad or depressed	○	○	○
Feeling anxious or on edge	○	○	○
Feeling a lot of fear when being away from parent or caregiver	○	○	○
Feeling a lot of fear of specific things like spiders or being up high	○	○	○
Feeling a lot of fear about being with other children or adults	○	○	○
Feeling fear of crowds or being in closed-in spaces	○	○	○
Having a sudden intense feeling of fear, like a panic attack	○	○	○
Refusing to go to school	○	○	○
Having a lot of tantrums	○	○	○
Holding their breath for a long time when they are afraid or angry	○	○	○
Having nightmares	○	○	○
Screaming in fear while asleep, sometimes called night terrors	○	○	○
Seeing, hearing, or feeling that something is there when it is not (hallucinations)	○	○	○
Aggressive behavior like hitting, biting or kicking	○	○	○
Rocking the body back and forth or head banging	○	○	○
Being hyperactive or much more active than other children	○	○	○
Refusing to follow rules or doing what they are asked to do	○	○	○

Serious breaking of rules like lying, stealing, starting fights, or bullying	○	○	○
Having repeating memories, dreams, thoughts, or worries after a traumatic event	○	○	○

Symptoms or problems involving periods:

	Yes	No	I don't know
Getting periods less often	○	○	○
Getting periods more often	○	○	○
Heavier periods	○	○	○
Lighter periods	○	○	○

Now, we are going to ask about any problems or symptoms [sname_you] [sv_has] now.

[sv_does_cap] [sname_you] have any of these problems or symptoms now?

General symptoms or problems:

	Yes	No	I don't know
Fever	○	○	○
Feeling sleepy during the day time	○	○	○
Trouble sleeping	○	○	○
Fussy or cranky (crying a lot)	○	○	○
Low energy or not feeling strong enough to do things	○	○	○
Feeling very tired all day long	○	○	○
Feeling very tired after walking	○	○	○
Sweating more than normal	○	○	○
Hot and cold spells (feeling hot or cold for no reason)	○	○	○
Not wanting to eat (poor appetite)	○	○	○
Wanting to eat more than normal (increased appetite)	○	○	○
Wanting to drink liquids more than normal (increased thirst)	○	○	○
Lost weight or gained less than expected	○	○	○
Gained weight more than expected	○	○	○

Lost height or grew less than expected	○	○	○

Symptoms or problems in the eyes, ears, nose, and throat:

	Yes	No	I don't know
Eyes look red	○	○	○
Eyes are watery	○	○	○
Eyes are dry	○	○	○
Dark circles or color under the eyes	○	○	○
Trouble seeing or blurry vision	○	○	○
Light hurts your eyes	○	○	○
Change in hearing	○	○	○
Ringing in the ears	○	○	○
Stuffy nose or runny nose	○	○	○
Change in smell	○	○	○
Loss of smell	○	○	○
Very dry mouth	○	○	○
Throat hurts (sore throat)	○	○	○
Loss of voice (sounding hoarse)	○	○	○
Problems swallowing	○	○	○
Change in how things taste	○	○	○
Problems with teeth or gums	○	○	○
Chapped lips	○	○	○

Symptoms or problems involving the heart and lungs:

	Yes	No	I don't know
Dry cough	○	○	○
Wet cough (brings up mucus)	○	○	○
Barking cough	○	○	○
Trouble breathing (breathing too fast)	○	○	○
Pain when breathing	○	○	○
Pain in the chest	○	○	○
Feeling like your heart is beating really fast, racing, or pounding (called palpitations) when not doing exercise	○	○	○
Feeling like your heart is beating really fast when doing exercise	○	○	○

Fainting or feeling like you are going to faint (lightheaded)	○	○	○
Trouble walking	○	○	○
Trouble climbing stairs	○	○	○
Trouble running	○	○	○

Symptoms or problems involving the belly:

	Yes	No	I don't know
Stomach pains/cramps	○	○	○
Nausea (feeling like you are going to throw up)	○	○	○
Throwing up (vomiting)	○	○	○
Loose stool (diarrhea)	○	○	○
Trouble pooping/stooling (constipation)	○	○	○
Pain with peeing (urination)	○	○	○
Peeing more than normal (urination more than normal)	○	○	○

Symptoms or problems involving the skin, hair, and nails:

	Yes	No	I don't know
Skin rash	○	○	○
Itchiness of the skin	○	○	○
Changes or problems with nails	○	○	○
Changes or problems with hair	○	○	○
Color changes in your skin, such as red, white or purple	○	○	○
Color changes on the fingers or toes	○	○	○

Symptoms or problems involving the bones and muscles:

	Yes	No	I don't know
Muscle weakness	○	○	○
Sore muscles or pain in the muscles	○	○	○
Body aches or pains	○	○	○
Pains in the joints (like the elbows, knees, ankles)	○	○	○
Pain in the back	○	○	○
Pain in the neck	○	○	○

Symptoms or problems involving the brain and nerves:

	Yes	No	I don't know
Headache	○	○	○
Feeling dizzy (feeling like the room is spinning)	○	○	○
Shakiness or tremors	○	○	○
Feeling tingling or 'pin-and-needles' in the hands and feet	○	○	○
Unable to move part of the body	○	○	○
Problems with remembering things (memory)	○	○	○
Problems with focusing on things (concentration), sometimes called "brain fog"	○	○	○
Problems with talking	○	○	○

Symptoms or problems involving feelings or behavior:

	Yes	No	I don't know
Feeling sad or depressed	○	○	○
Feeling anxious or on edge	○	○	○
Feeling a lot of fear when being away from parent or caregiver	○	○	○
Feeling a lot of fear of specific things like spiders or being up high	○	○	○
Feeling a lot of fear about being with other children or adults	○	○	○
Feeling fear of crowds or being in closed-in spaces	○	○	○
Having a sudden intense feeling of fear, like a panic attack	○	○	○
Refusing to go to school	○	○	○
Having a lot of tantrums	○	○	○
Holding their breath for a long time when they are afraid or angry	○	○	○
Having nightmares	○	○	○
Screaming in fear while asleep, sometimes called night terrors	○	○	○
Seeing, hearing, or feeling that something is there when it is not (hallucinations)	○	○	○

Aggressive behavior like hitting, biting or kicking	○	○	○
Rocking the body back and forth or head banging	○	○	○
Being hyperactive or much more active than other children	○	○	○
Refusing to follow rules or doing what they are asked to do	○	○	○
Serious breaking of rules like lying, stealing, starting fights, or bullying	○	○	○
Having repeating memories, dreams, thoughts, or worries after a traumatic event	○	○	○

Symptoms or problems involving periods:

	Yes	No	I don't know
Getting periods less often	○	○	○
Getting periods more often	○	○	○
Heavier periods	○	○	○
Lighter periods	○	○	○

COVID Testing History

ERROR! You must complete the visit form before you can start this form.

Form collection date: _____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

Now we are going to ask you questions about [sname_your_poss] most recent COVID test.

[sv_has_cap] [sname_you] ever been tested for COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What year was [sname_your_poss] most recent COVID test? _____

In [cth_dty], what month did [sname_you] have [sp_their_your] most recent COVID test?

◯ January
◯ February
◯ March
◯ April
◯ May
◯ June
◯ July
◯ August
◯ September
◯ October
◯ November
◯ December

How [sv_was] [sname_you] tested for [sp_their_your] most recent test?

☐ Antigen test done in a laboratory, doctor's office, or testing center (sometimes called a rapid test)
☐ Antigen test done at home (sometimes called a rapid test)
☐ PCR/molecular test, throat, or nose swab
☐ Blood test for antibodies
☐ I don't know
☐ [sname_i] didn't have a test
☐ I do not want to answer

Please tell us if you agree with the following statements about COVID testing.

	Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree

In the first year of the pandemic in 2020, I knew where I could get [sname_myself] tested for COVID near where I live.	○	○	○	○	○
In the first year of the pandemic in 2020, it was easy to get [sname_myself] tested for COVID.	○	○	○	○	○
Now, I know where I could get [sname_myself] tested for COVID near where I live.	○	○	○	○	○
Now, it is easy to get [sname_myself] tested for COVID.	○	○	○	○	○

COVID Vaccine History

ERROR! You must complete the visit form before you can start this form.

What is the date that this survey is being done?

_____
(MM-DD-YYYY)

Check this box if the coordinator is entering data: ☐ Coordinator data entry

Now we are going to ask you about COVID vaccines.

[sv_has_cap] [sname_you] gotten a COVID vaccine?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

If yes, how many shots [sv_has] [sname_you] had (including boosters)?

◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10 or more
(shots)

For the first shot, which vaccine did [sname_you] have?

◯ Pfizer
◯ Moderna
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other _____
◯ I don't know
◯ I do not want to answer

Please explain which vaccine [sname_you] had:

_____

Date of first vaccine dose (If you don't remember the exact date, that is okay. Try your best.)

_____

Check this if you truly unable to remember date of first vaccination, and unable to find the CDC issued COVID vaccination card.

☐ Unable to remember AND lost the CDC vaccination card

If you can not remember, please estimate the month of the first COVID vaccine:

◯ January
◯ February
◯ March
◯ April
◯ May
◯ June
◯ July
◯ August
◯ September
◯ October
◯ November
◯ December

If you can not remember, please estimate the year of the first COVID vaccine: _____

For the second shot, which vaccine did [sname_you] have?

◯ Pfizer
◯ Moderna
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other _____
◯ I don't know
◯ I do not want to answer

Please explain which vaccine [sname_you] had: _____

Date of second vaccine dose: (If you don't remember the exact date, that is okay. Try your best.) _____

Check this if you truly unable to remember date of second vaccination, and unable to find the CDC issued COVID vaccination card.

☐ Unable to remember AND lost the CDC vaccination card

If you can not remember, please estimate the month of the second COVID vaccine:

◯ January
◯ February
◯ March
◯ April
◯ May
◯ June
◯ July
◯ August
◯ September
◯ October
◯ November
◯ December

If you can not remember, please estimate the year of the second COVID vaccine: _____

For the third shot, which vaccine did [sname_you] have?

◯ Pfizer
◯ Moderna
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other _____
◯ I don't know
◯ I do not want to answer

Please explain which vaccine [sname_you] had: _____

Date of third vaccine dose: (If you don't remember the exact date, that is okay. Try your best.) _____

Check this if you truly unable to remember date of third vaccination, and unable to find the CDC issued COVID vaccination card.

☐ Unable to remember AND lost the CDC vaccination card

If you can not remember, please estimate the month of the third COVID vaccine:

◯ January
◯ February
◯ March
◯ April
◯ May
◯ June
◯ July
◯ August
◯ September
◯ October
◯ November
◯ December

If you can not remember, please estimate the year of the third COVID vaccine: _____

For the fourth shot, which vaccine did [sname_you] have?

◯ Pfizer
◯ Moderna
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other _____
◯ I don't know
◯ I do not want to answer

Please explain which vaccine [sname_you] had: _____

Date of fourth vaccine dose: (If you don't remember the exact date, that is okay. Try your best.) _____

Check this if you truly unable to remember date of fourth vaccination, and unable to find the CDC issued COVID vaccination card.

☐ Unable to remember AND lost the CDC vaccination card

If you can not remember, please estimate the month of the fourth COVID vaccine:

◯ January
◯ February
◯ March
◯ April
◯ May
◯ June
◯ July
◯ August
◯ September
◯ October
◯ November
◯ December

If you can not remember, please estimate the year of the fourth COVID vaccine: _____

For the fifth shot, which vaccine did [sname_you] have?

◯ Pfizer
◯ Moderna
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other _____
◯ I don't know
◯ I do not want to answer

Please explain which vaccine [sname_you] had: _____

Date of fifth vaccine dose: (If you don't remember the exact date, that is okay. Try your best.) _____

Check this if you truly unable to remember date of fifth vaccination, and unable to find the CDC issued COVID vaccination card.

☐ Unable to remember AND lost the CDC vaccination card

If you can not remember, please estimate the month of the fifth COVID vaccine:

◯ January
◯ February
◯ March
◯ April
◯ May
◯ June
◯ July
◯ August
◯ September
◯ October
◯ November
◯ December

If you can not remember, please estimate the year of the fifth COVID vaccine: _____

For the sixth shot, which vaccine did [sname_you] have?

◯ Pfizer
◯ Moderna
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other _____
◯ I don't know
◯ I do not want to answer

Please explain which vaccine [sname_you] had: _____

Date of sixth vaccine dose: (If you don't remember the exact date, that is okay. Try your best.) _____

Check this if you truly unable to remember date of sixth vaccination, and unable to find the CDC issued COVID vaccination card.

☐ Unable to remember AND lost the CDC vaccination card

If you can not remember, please estimate the month of the sixth COVID vaccine:

◯ January
◯ February
◯ March
◯ April
◯ May
◯ June
◯ July
◯ August
◯ September
◯ October
◯ November
◯ December

If you can not remember, please estimate the year of the sixth COVID vaccine: _____

For the seventh shot, which vaccine did [sname_you] have?

◯ Pfizer
◯ Moderna
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other _____
◯ I don't know
◯ I do not want to answer

Please explain which vaccine [sname_you] had: _____

Date of seventh vaccine dose: (If you don't remember the exact date, that is okay. Try your best.) _____

Check this if you truly unable to remember date of seventh vaccination, and unable to find the CDC issued COVID vaccination card.

☐ Unable to remember AND lost the CDC vaccination card

If you can not remember, please estimate the month of the seventh COVID vaccine:

◯ January
◯ February
◯ March
◯ April
◯ May
◯ June
◯ July
◯ August
◯ September
◯ October
◯ November
◯ December

If you can not remember, please estimate the year of the seventh COVID vaccine: _____

For the eighth shot, which vaccine did [sname_you] have?

◯ Pfizer
◯ Moderna
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other _____
◯ I don't know
◯ I do not want to answer

Please explain which vaccine [sname_you] had: _____

Date of eighth vaccine dose: (If you don't remember the exact date, that is okay. Try your best.) _____

Check this if you truly unable to remember date of eighth vaccination, and unable to find the CDC issued COVID vaccination card.

☐ Unable to remember AND lost the CDC vaccination card

If you can not remember, please estimate the month of the eighth COVID vaccine:

◯ January
◯ February
◯ March
◯ April
◯ May
◯ June
◯ July
◯ August
◯ September
◯ October
◯ November
◯ December

If you can not remember, please estimate the year of the eighth COVID vaccine: _____

For the ninth shot, which vaccine did [sname_you] have?

◯ Pfizer
◯ Moderna
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other _____
◯ I don't know
◯ I do not want to answer

Please explain which vaccine [sname_you] had: _____

Date of ninth vaccine dose: (If you don't remember the exact date, that is okay. Try your best.) _____

Check this if you truly unable to remember date of ninth vaccination, and unable to find the CDC issued COVID vaccination card.

☐ Unable to remember AND lost the CDC vaccination card

If you can not remember, please estimate the month of the ninth COVID vaccine:

◯ January
◯ February
◯ March
◯ April
◯ May
◯ June
◯ July
◯ August
◯ September
◯ October
◯ November
◯ December

If you can not remember, please estimate the year of the ninth COVID vaccine: _____

For the tenth shot, which vaccine did [sname_you] have?

◯ Pfizer
◯ Moderna
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other _____
◯ I don't know
◯ I do not want to answer

Please explain which vaccine [sname_you] had: _____

Date of tenth vaccine dose: (If you don't remember the exact date, that is okay. Try your best.) _____

Check this if you truly unable to remember date of tenth vaccination, and unable to find the CDC issued COVID vaccination card.

☐ Unable to remember AND lost the CDC vaccination card

If you can not remember, please estimate the month of the tenth COVID vaccine:

◯ January
◯ February
◯ March
◯ April
◯ May
◯ June
◯ July
◯ August
◯ September
◯ October
◯ November
◯ December

If you can not remember, please estimate the year of the tenth COVID vaccine: _____

Did the vaccine change the problems or symptoms [sname_you] had from COVID?

◯ No
◯ Yes
◯ I don't know
◯ I do not want to answer
◯ [sname_i] did not have problems and symptoms from COVID when [sp_they_i] got the vaccine

If yes, how did these symptoms change?

◯ Vaccine made the symptoms better
◯ Vaccine made the symptoms worse
◯ Some symptoms got better and some got worse

Did [sname_your_poss] birth mother get the COVID vaccine while pregnant?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Did [sname_your_poss] birth mother get the COVID vaccine while breastfeeding?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What are your plans about the COVID vaccine for [sname_yourself]?

◯ I plan on getting the COVID vaccine for [sname_myself] soon
◯ I plan on getting the COVID vaccine for [sname_myself] in the future
◯ I do not plan on getting the COVID vaccine for [sname_myself]
◯ I don't know
◯ I do not want to answer

Why [sv_has] [sname_you] not gotten the COVID vaccine? Choose one or more of these.

☐ The COVID vaccine was not available because [sname_i] was too young
☐ A doctor or healthcare provider did not recommend it
☐ My friends and family did not recommend it
☐ I have read information that suggests it is unsafe
☐ I cannot afford the vaccine
☐ I do not have time [vacc_nreas_subst] the vaccine
☐ [sname_i] [sv_is_am] at low risk of getting sick and [sv_does] not need it
☐ It is riskier to go and get the vaccine than to stay at home
☐ I am worried about the side effects
☐ I am worried that [sname_i] could get heart problems (myocarditis) from the vaccine
☐ The vaccine's technology hasn't been tested enough
☐ The vaccine was approved too fast
☐ I do not trust the government to make a safe vaccine
☐ I do not trust the research to make a safe vaccine
☐ No long-term safety data are available
☐ I am concerned about vaccine storage
☐ [sname_i] already had a COVID infection
☐ Other _____

Please explain why [sname_you] [sv_has] not gotten the COVID vaccine: _____

Current COVID Infection History

ERROR! You must complete the visit form before you can start this form.

Date Current COVID Infection History form collected:

_____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

Now we are going to ask about [sname_your_poss] experience with COVID in the past 30 days.

Do you feel that [sname_you] had a COVID infection in the past 30 days?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Why do you think [sname_you] did not have a COVID infection in the past 30 days? (You can choose one or more of these)

☐ Never had symptoms ([sname_i] did not show any signs of being sick, like a fever or cough)
☐ Had symptoms but my doctor said they weren't COVID
☐ Had negative testing
☐ Never was near anyone who had COVID
☐ Other

Please explain why you do not think [sname_you] did not have a COVID infection in the past 30 days:

What date did this current COVID infection start on?

_____

How did you learn that [sname_you] [sv_was] infected during this COVID infection? Choose one or more of these

☐ A doctor told me [sname_i] had COVID because [sname_i] had symptoms
☐ I thought [sname_i] had COVID at this time, but a doctor did not tell me [sname_i] had COVID
☐ A test done at a doctor's office or laboratory said that [sname_i] had COVID
☐ A test done at home said that [sname_i] had COVID
☐ A test done at school said that [sname_i] had COVID
☐ I don't know
☐ I do not want to answer

If [sname_you] [sv_was] tested for COVID when this infection started in [ccih_dt], what type of test(s) did [sname_you] get? You can choose one or more of these.

☐ Antigen test done in a laboratory, doctor's office, or testing center (sometimes called a rapid test)
☐ Antigen test done at home (sometimes called a rapid test)
☐ PCR/molecular test, throat or nose swab
☐ Blood test for antibodies
☐ [sname_i] didn't have a test
☐ I don't know
☐ I do not want to answer

Were any of the results positive for COVID (showed that [sname_you] had COVID)?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Which test was positive? You can choose one or more of these.

☐ Antigen test done in a laboratory, doctor's office, or testing center (sometimes called a rapid test)
☐ Antigen test done at home (sometimes called a rapid test)
☐ PCR/molecular test, throat or nose swab
☐ Blood test for antibodies
☐ I don't know
☐ I do not want to answer

What was the date of [sname_your_poss] first positive test for this COVID infection? _____

When [sname_you] got this COVID infection, did [sname_you] have any symptoms? Symptoms are signs of being sick, like having a fever or a cough.

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you remember the date that [sname_your_poss] symptoms started?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What was the date [sname_you] first got symptoms for this COVID infection? _____

About how long [sv_has] [sname_you] had symptoms?

◯ 1 week or less
◯ 2 weeks
◯ 3 weeks
◯ 4 weeks
◯ More than 4 weeks
◯ I don't know
◯ I do not want to answer

How bad, or severe, are [sname_your_poss] symptoms now?

◯ Very mild (slightly bad)
◯ Mild (a little bad)
◯ Moderate (medium bad)
◯ Severe (very bad)
◯ Extreme (extremely bad)
◯ Life-threatening (almost died from COVID)
◯ I don't know
◯ I do not want to answer

What kind of health care [sv_has] [sname_you] gotten for this COVID infection? Choose one or more of these.

☐ I was able to take care of [sname_myself] at home without talking with [sname_my_poss] doctor's office
☐ I took care of [sname_myself] at home and talked to [sname_my_poss] doctor by phone
☐ I took care of [sname_myself] at home and talked to [sname_my_poss] doctor using an online video visit
☐ [sname_i] was seen in person at [sp_their_my] regular doctor's office
☐ [sname_i] was seen at an urgent care facility (a place where you can walk in to get care right away without an appointment)
☐ [sname_i] was seen at the emergency department
☐ I don't know
☐ I do not want to answer

[sv_has_cap] [sname_you] had to stay in the hospital (get admitted) during this COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What was the date [sname_you] had to stay in the hospital (got admitted)? _____

[sv_is_cap] [sname_you] still in the hospital?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What date [sv_was] [sname_you] sent home from the hospital? _____

[sv_has_cap] [sname_you] had to stay in the [ccih_picu_calcya] during this COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What was the date [sname_you] had to stay in the [ccih_picu_calcya]? _____

[sv_is_cap] [sname_you] still in the [ccih_picu_calcya]?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What date [sv_was] [sname_you] sent home from the [ccih_picu_calcya]? _____

[sv_has_cap] [sname_you] gotten any of the following treatments during this COVID infection?

	Yes	No	I don't know	I do not want to answer
Oxygen therapy (extra oxygen is given when a person's oxygen is low)	◯	◯	◯	◯
Intravenous fluids (giving fluids through a needle placed in a blood vessel)	◯	◯	◯	◯
Treatment with steroids (medicines that help decrease swelling (inflammation) in the body)	◯	◯	◯	◯
Treatment with hydroxychloroquine (medicine mostly used to treat malaria that has been studied for treating and preventing COVID)	◯	◯	◯	◯
Treatment with antiviral drug (medicines used to treat infections caused by a virus)	◯	◯	◯	◯
Treatment with monoclonal antibody (proteins made in a lab that act like the body's antibodies, to help the immune system find and kill germs)	◯	◯	◯	◯
Treatment with convalescent plasma (giving a person the plasma part of COVID survivors' blood, which may have antibodies to the virus that causes COVID)	◯	◯	◯	◯
Treatment with blood thinner (medicines used to treat or prevent blood clots)	◯	◯	◯	◯

Treatment with antibiotics (medicines used to treat infections caused by bacteria)	○	○	○	○
Breathing tube / breathing machine (ventilator which acts like the lungs when a person can't breathe on their own)	○	○	○	○
Dialysis (treatment that helps clean the blood when the kidneys are hurt, or not working)	○	○	○	○
Other	○	○	○	○

What other treatments for COVID did [sname_you] get?

Demographics

ERROR! You must complete the visit form before you can start this form.

Date of Demographic Data Collection

_____
(MM/DD/YYYY)

Check this box if the coordinator is entering data: ☐ Coordinator data entry

Now we are going to ask you questions about [sname_yourself].

What is [sname_your_poss] birthday?

_____

What was [sname_your_poss] sex assigned at birth?

◯ Female
◯ Male
◯ Intersex
◯ None of these describe [sname_me]
◯ I don't know
◯ I do not want to answer

How do you describe [sname_your_poss] gender identity?

◯ [demo_womangirl_calcya]
◯ [demo_manboy_calcya]
◯ Non-binary
◯ Transgender
◯ None of these describe [sname_me] and I'd like to see other words
◯ I don't know
◯ I do not want to answer

Do any of these describe [sname_your_poss] identity? (You can choose one or more of these)
(You can choose one of more of these)

☐ Transgender Man/Transgender Boy/Female-to-male (FTM)
☐ Transgender Woman/Transgender Girl/Male-to-female (MTF)
☐ Genderqueer
☐ Genderfluid
☐ Gender variant
☐ [sname_i] [sv_is] questioning or not sure of [sp_their_my] gender identity
☐ None of these describe [sname_me]
☐ I don't know
☐ I do not want to answer

Which group(s) best describe [sname_you]? Please check all groups that describe [sname_you].
(You can choose one of more of these)

- ☐ American Indian or Alaska Native(For example: Aztec, Blackfeet Tribe, Mayan, Navajo Nation, Native Village of Barrow (Utqiagvik) Inupiat Traditional Government, Nome Eskimo Community, etc.)
- ☐ Asian(For example: Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, etc.)
- ☐ Black or African American(For example: African American, Ethiopian, Haitian, Jamaican, Nigerian, Somali, etc.)
- ☐ Hispanic, Latino, or Spanish(For example: Colombian, Cuban, Dominican, Mexican or Mexican American, Puerto Rican, Salvadoran, etc.)
- ☐ Middle Eastern or North African(For example: Algerian, Egyptian, Iranian, Lebanese, Moroccan, Syrian, etc.)
- ☐ Native Hawaiian or other Pacific Islander(For example: Chamorro, Fijian, Marshallese, Native Hawaiian, Tongan, etc.)
- ☐ White(For example: English, European, French, German, Irish, Italian, Polish, etc.)
- ☐ None of these fully describe [sname_me]
- ☐ I don't know
- ☐ I do not want to answer

Which of these American Indian or Alaska Native groups best describes [sname_you]? (You can choose one or more of these)

- ☐ American Indian
- ☐ Alaska Native
- ☐ Central or South American Indian
- ☐ None of these fully describe [sname_me]
- ☐ I don't know
- ☐ I do not want to answer

Which of these Asian groups best describes [sname_you]? (You can choose one or more of these)
(You can choose one of more of these)

- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Pakistani
- ☐ Vietnamese
- ☐ Other Asian group
- ☐ I don't know
- ☐ I do not want to answer

Which of these Black or African groups best describes [sname_you]? (You can choose one or more of these)
(You can choose one of more of these)

- ☐ African American
- ☐ Barbadian
- ☐ Caribbean
- ☐ Ethiopian
- ☐ Ghanaian
- ☐ Haitian
- ☐ Jamaican
- ☐ Liberian
- ☐ Nigerian
- ☐ Somali
- ☐ South African
- ☐ Other Black or African group
- ☐ I don't know
- ☐ I do not want to answer

Which of these Hispanic groups best describes [sname_you]? (You can choose one or more of these)
(You can choose one of more of these)

- ☐ Colombian
- ☐ Cuban
- ☐ Dominican
- ☐ Ecuadorian
- ☐ Honduran
- ☐ Mexican or Mexican American
- ☐ Puerto Rican
- ☐ Salvadoran
- ☐ Spanish
- ☐ Other Hispanic group
- ☐ I don't know
- ☐ I do not want to answer

Which of these Middle Eastern or North African groups best describes [sname_you]? (You can choose one or more of these)
(You can choose one of more of these)

- ☐ Afghan
- ☐ Algerian
- ☐ Egyptian
- ☐ Iranian
- ☐ Iraqi
- ☐ Israeli
- ☐ Lebanese
- ☐ Moroccan
- ☐ Syrian Tunisian
- ☐ Other Middle Eastern or North African group
- ☐ I don't know
- ☐ I do not want to answer

Which of these Native Hawaiian or Pacific Islander groups best describes [sname_you]? (You can choose one or more of these)
(You can choose one of more of these)

- ☐ Chamorro
- ☐ Chuukese
- ☐ Fijian
- ☐ Kosraen
- ☐ Maori
- ☐ Marshallese
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Palauan
- ☐ Pohnpeian
- ☐ Samoan
- ☐ Tahitian
- ☐ Tongan
- ☐ Yapese
- ☐ Other Pacific Islander group
- ☐ I don't know
- ☐ I do not want to answer

Which of these White or European groups best describes [sname_you]? (You can choose one or more of these)
(You can choose one of more of these)

- ☐ Dutch
- ☐ English
- ☐ French
- ☐ German
- ☐ Irish
- ☐ Italian
- ☐ Norwegian
- ☐ Polish
- ☐ Russian
- ☐ Scottish
- ☐ Spanish
- ☐ Other White or European group _____
- ☐ I don't know
- ☐ I do not want to answer

If others, please describe:

_____

If none of these describe [sname_you], please explain

Is English the main language [sname_you] speak[sv_3pend]?

- ◯ Yes
- ◯ No
- ◯ I don't know
- ◯ I do not want to answer

What language(s) other than English [sv_does] [sname_you] speak? (You can choose one or more of these)

☐ Spanish
☐ Vietnamese
☐ Mandarin
☐ Cantonese
☐ Tagalog
☐ Hawaiian
☐ Ilocano
☐ Navajo
☐ Russian
☐ Hindi
☐ Haitian Creole
☐ Cape Verdean Creole
☐ French
☐ Arabic
☐ Other
☐ [sname_i] only speak[sv_3pend] English
☐ I don't know
☐ I do not want to answer

What other language(s) [sv_does] [sname_you] speak? _____

Where [sv_was] [sname_you] born?

◯ In the United States or a United States territory
◯ Outside the United States and territories
◯ I don't know
◯ I do not want to answer

[sv_is_cap] [sname_you] currently in school? If [sname_you] [sv_is] between school years (for example, it is summer) but attend[sv_3pend] school during the school year, you should answer yes. If [sname_you] [sv_is] home schooled, you should also answer yes.

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What type of school [sv_does] [sname_you] go to?

◯ Public school
◯ Private school
◯ Home school
◯ Daycare
◯ Other, please explain _____
◯ I don't know
◯ I do not want to answer

Please explain what type of school [sname_you] attend[sv_3pend]: _____

What grade [sv_is] [sname_you] in? If [sname_you] [sv_is] currently between grades (for example, it is summer), please pick the grade [sp_they_you] will be starting in the next school year.

◯ Pre-school/pre-kindergarten
◯ Kindergarten
◯ 1st grade
◯ 2nd grade
◯ 3rd grade
◯ 4th grade
◯ 5th grade
◯ 6th grade
◯ 7th grade
◯ 8th grade
◯ 9th grade
◯ 10th grade
◯ 11th grade
◯ 12th grade
◯ College or University
◯ Graduate school
◯ [sname_i] [sv_is_am] not in school
◯ I don't know
◯ I do not want to answer

First COVID Infection History

ERROR! You must complete the visit form before you can start this form.

Date First COVID Infection History form collected: _____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

[fcih_covquestext]

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

This form is not required for this participant. Please click cancel.

How many COVID infections [sv_has] [sname_you] had, not including this one:

◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10
◯ 11
◯ 12
◯ 13
◯ 14
◯ 15
◯ 16
◯ 17
◯ 18
◯ 19
◯ 20 or more

Think about the first time [sname_you] ever had a COVID infection.

Some people may get COVID more than once. Here, we are asking about [sname_your_poss] first COVID infection.

What year was the first time [sname_you] had a COVID infection? _____

In [fcih_dty], the first time you said [sname_you] had a COVID infection, what month was it?

◯ January
◯ February
◯ March
◯ April
◯ May
◯ June
◯ July
◯ August
◯ September
◯ October
◯ November
◯ December

Why did you think [sname_you] had COVID in [fcih_dtm] [fcih_dty] (the first time [sname_you] had COVID)? Choose one or more of these:

☐ A doctor told me [sname_i] had COVID because [sname_i] had symptoms
☐ I thought [sname_i] had COVID at this time, but a doctor did not tell me [sname_i] had COVID
☐ A test done at a doctor's office or laboratory said that [sname_i] had COVID
☐ A test done at home said that [sname_i] had COVID
☐ A test done at school said that [sname_i] had COVID
☐ I don't know
☐ I do not want to answer

If [sname_you] [sv_was] tested for COVID in [fcih_dtm] [fcih_dty], what type of test(s) did [sname_you] get? You can choose one or more of these.

☐ Antigen test done in a laboratory, doctor's office, or testing center (sometimes called a rapid test)
☐ Antigen test done at home (sometimes called a rapid test)
☐ PCR/molecular test, throat or nose swab
☐ Blood test for antibodies
☐ I don't know
☐ [sname_i] didn't have a test
☐ I do not want to answer

Were any of the results positive for COVID (showed that [sname_you] had COVID)?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Which test was positive? You can choose one or more of these.

☐ Antigen test done in a laboratory, doctor's office, or testing center (sometimes called a rapid test)
☐ Antigen test done at home (sometimes called a rapid test)
☐ PCR/molecular test, throat or nose swab
☐ Blood test for antibodies
☐ I don't know
☐ I do not want to answer

The first time [sname_you] had COVID, did [sname_you] have any symptoms? Symptoms are signs of being sick, like having a fever or cough.

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

The first time [sname_you] had COVID, how long did [sname_your_poss] symptoms last?

◯ 1 week or less
◯ 2 weeks
◯ 3 weeks
◯ 4 weeks
◯ More than 4 weeks
◯ I don't know
◯ I do not want to answer

During [sname_your_poss] first COVID infection, how bad, or severe, were [sname_your_poss] symptoms?

◯ Very mild (slightly bad)
◯ Mild (a little bad)
◯ Moderate (medium bad)
◯ Severe (very bad)
◯ Extreme (extremely bad)
◯ Life-threatening (almost died from COVID)
◯ I don't know
◯ I do not want to answer

The first time [sname_you] had COVID, what kind of health care did [sname_you] get? Choose one or more of these.

☐ I was able to take care of [sname_myself] at home without talking with [sname_my_poss] doctor's office
☐ I took care of [sname_myself] at home and talked to [sname_my_poss] doctor by phone
☐ I took care of [sname_myself] at home and talked to [sname_my_poss] doctor using an online video visit
☐ [sname_i] was seen in person at [sname_my_poss] regular doctor's office
☐ [sname_i] was seen at an urgent care facility (a place where you can walk in to get care right away without an appointment)
☐ [sname_i] was seen at the emergency department
☐ I don't know
☐ I do not want to answer

The first time [sname_you] had COVID, did [sname_you] have to stay in the hospital (get admitted)?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

How many days [sv_was] [sname_you] in the hospital?

_____
(days)

At any time during the first time [sname_you] had COVID, did [sname_you] have to stay in the [fcih_picu_calcya]?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

For how many days [sv_was] [sname_you] in the [fcih_picu_calcya]?

_____
(days)

The first time [sname_you] had COVID, did [sp_they_you] get any of the following treatments?

	Yes	No	I don't know	I do not want to answer
Oxygen therapy (extra oxygen is given when a person's oxygen is low)	○	○	○	○
Intravenous fluids (giving fluids through a needle placed in a blood vessel)	○	○	○	○
Treatment with steroids (medicines that help decrease swelling (inflammation) in the body)	○	○	○	○
Treatment with hydroxychloroquine (medicine mostly used to treat malaria that has been studied for treating and preventing COVID)	○	○	○	○
Treatment with antiviral drug (medicines used to treat infections caused by a virus)	○	○	○	○
Treatment with monoclonal antibody (proteins made in a lab that act like the body's antibodies, to help the immune system find and kill germs)	○	○	○	○
Treatment with convalescent plasma (giving a person the plasma part of COVID survivors' blood, which may have antibodies to the virus that causes COVID)	○	○	○	○
Treatment with blood thinner (medicines used to treat or prevent blood clots)	○	○	○	○
Treatment with antibiotics (medicines used to treat infections caused by bacteria)	○	○	○	○
Breathing tube / breathing machine (ventilator which acts like the lungs when a person can't breathe on their own)	○	○	○	○
Dialysis (treatment that helps clean the blood when the kidneys are hurt, or not working)	○	○	○	○
Other	○	○	○	○

What other treatments for COVID did [sname_you] get?

Identity

ERROR! You must complete the visit form before you can start this form.

What is the date that this survey is being done?

_____
(MM-DD-YYYY)

Check this box if the coordinator is entering data: ☐ Coordinator data entry

The person completing this survey should be the main caregiver for the child who is part of this study ([sname]). The main caregiver is a person, like a family member (biological (blood related) or non-biological (not blood related)) or guardian, who is in charge of taking care of the child who is part of this study. The main caregiver:Is the person who spends the most time with the child.Is the person most responsible for taking care of the child every day.Lives in the same home as the child.Knows the most about the child.Must be older than 18 years of age if the main caregiver is not blood related.Are you the main caregiver for the child who is part of this study ([sname])?

◯ Yes
◯ No

What is [id_yourchild_calcya] first name?

_____

The research site has used the name "[sname]" for [id_yourchild_calcya] name. This name has already been used to create the surveys, and will be used in all the questions.

What is [sname_your_poss] last name?

_____

MISC and POTS

ERROR! You must complete the visit form before you can start this form.

Date of form completion

_____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

The following questions ask if [sname_you] had any of the following health problems.

Have you ever been told that [sname_you] [sv_has] Multisystem Inflammatory Syndrome in Children (MIS-C)?MIS-C is when a child's immune system causes serious inflammation (swelling) in their body after fighting COVID. The inflammation can damage organs, like their heart, lungs, blood vessels, and brain. Some symptoms include a fever, throwing up (vomiting), diarrhea, belly pain, skin rash, blood shot eyes, and dizziness.

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What year were you told that [sname_you] had Multisystem Inflammatory Syndrome in Children (MIS-C)?

_____
(year)

What month were you told that [sname_you] had Multisystem Inflammatory Syndrome in Children (MIS-C)?

◯ January
◯ February
◯ March
◯ April
◯ May
◯ June
◯ July
◯ August
◯ September
◯ October
◯ November
◯ December

Have you ever been told that [sname_you] [sv_has] POTS (Postural Orthostatic Tachycardia Syndrome) or other form of dysautonomia or autonomic dysfunction?POTS is a condition where people feel dizzy or feel like passing out (fainting) when they stand up after lying down. Their heart rate goes up during this time. POTS happens when peoples' autonomic nervous system doesn't work the right way. This is the part of the nervous system that controls important functions like breathing, blood pressure, and heart rate (pulse). Dysautonomia and autonomic dysfunction also mean health problems where the autonomic nervous system doesn't work right or is damaged.

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What year were you told that [sname_you] had POTS (Postural Orthostatic Tachycardia Syndrome) or another form of dysautonomia or autonomic dysfunction?

_____
(year)

What month were you told that [sname_you] had POTS (Postural Orthostatic Tachycardia Syndrome) or another form of dysautonomia or autonomic dysfunction?

- ◯ January
- ◯ February
- ◯ March
- ◯ April
- ◯ May
- ◯ June
- ◯ July
- ◯ August
- ◯ September
- ◯ October
- ◯ November
- ◯ December

Most Recent COVID Infection History

ERROR! You must complete the visit form before you can start this form.

ERROR! You must answer "yes" on the questions: "Do you feel that [sname_you] had COVID?" before engage this form.

Date Most Recent COVID Infection History form collected: _____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

Do you think [sname_you] ever had COVID again after the first time [sp_they_you] got it ([sp_their_your] first infection)?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

How many COVID infections did [sname_you] have not including the first one?

◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10
◯ 11
◯ 12
◯ 13
◯ 14
◯ 15
◯ 16
◯ 17
◯ 18
◯ 19
◯ 20 or more

Now we're going to ask about [sname_your_poss] experience with [sname_your_poss] MOST RECENT COVID infection.

What year was [sname_your_poss] most recent COVID infection? _____

What month did this COVID infection start?

◯ January
◯ February
◯ March
◯ April
◯ May
◯ June
◯ July
◯ August
◯ September
◯ October
◯ November
◯ December

Why did you think [sname_you] had COVID in [mrcih_dtm] [mrcih_dty] (the most recent time [sp_they_you] had COVID)? Choose one or more of these:

☐ A doctor told me [sname_i] had COVID because [sp_they_i] had symptoms
☐ I thought [sname_i] had COVID at this time, but a doctor did not tell me [sp_they_i] had COVID
☐ A test done at a doctor's office or laboratory said that [sname_i] had COVID
☐ A test done at home said that [sname_i] had COVID
☐ A test done at school said that [sname_i] had COVID
☐ I don't know
☐ I do not want to answer

If [sname_you] [sv_was] tested for COVID in [mrcih_dtm] [mrcih_dty], what type of test(s) did [sp_they_you] get? You can choose one or more of these.

☐ Antigen test done in a laboratory, doctor's office, or testing center (sometimes called a rapid test)
☐ Antigen test done at home (sometimes called a rapid test)
☐ PCR/molecular test, throat or nose swab
☐ Blood test for antibodies
☐ I don't know
☐ [sname_i] didn't have a test
☐ I do not want to answer

Were any of the results positive for COVID (showed that [sname_you] had COVID)?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Which test was positive? You can choose one or more of these.

☐ Antigen test done in a laboratory, doctor's office, or testing center (sometimes called a rapid test)
☐ Antigen test done at home (sometimes called a rapid test)
☐ PCR/molecular test, throat or nose swab
☐ Blood test for antibodies
☐ I don't know
☐ I do not want to answer

Did [sname_you] have any symptoms? Symptoms are signs of being sick, like having a fever or cough.

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

How long did [sname_your_poss] symptoms last?

◯ 1 week or less
◯ 2 weeks
◯ 3 weeks
◯ 4 weeks
◯ More than 4 weeks
◯ I don't know
◯ I do not want to answer

During [sname_your_poss] most recent COVID infection, how bad, or severe, were [sname_your_poss] symptoms?

◯ Very mild (slightly bad)
◯ Mild (a little bad)
◯ Moderate (medium bad)
◯ Severe (very bad)
◯ Extreme (extremely bad)
◯ Life-threatening (almost died from COVID)
◯ I don't know
◯ I do not want to answer

The most recent time [sname_you] had COVID, what kind of health care did [sp_they_you] get for this COVID infection? Choose one or more of these.

☐ I was able to take care of [sname_myself] at home without talking with [sname_my_poss] doctor's office
☐ I took care of [sname_myself] at home and talked to [sname_my_poss] doctor by phone
☐ I took care of [sname_myself] at home and talked to [sname_my_poss] doctor using an online video visit
☐ [sname_i] was seen in person at [sp_their_my] regular doctor's office
☐ [sname_i] was seen at an urgent care facility (a place where you can walk in to get care right away without an appointment)
☐ [sname_i] was seen at the emergency department
☐ I don't know
☐ I do not want to answer

During the last time [sname_you] had COVID, did [sp_they_you] have to stay in the hospital (get admitted)?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

How many days [sv_was] [sname_you] in the hospital for?

_____
(days)

Did [sname_you] have to stay in the [mrcih_picu_calcya] during this COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

How many days [sv_was] [sname_you] in the [mrcih_picu_calcya] for?

_____
(days)

The last time [sname_you] got COVID, did [sp_they_you] get any of the following treatments?

	Yes	No	I don't know	I do not want to answer
Oxygen therapy (extra oxygen is given when a person's oxygen is low)	○	○	○	○
Intravenous fluids (giving fluids through a needle placed in a blood vessel)	○	○	○	○
Treatment with steroids (medicines that help decrease swelling (inflammation) in the body)	○	○	○	○
Treatment with hydroxychloroquine (medicine mostly used to treat malaria that has been studied for treating and preventing COVID)	○	○	○	○
Treatment with antiviral drug (medicines used to treat infections caused by a virus)	○	○	○	○
Treatment with monoclonal antibody (proteins made in a lab that act like the body's antibodies, to help the immune system find and kill germs)	○	○	○	○
Treatment with convalescent plasma (giving a person the plasma part of COVID survivors' blood, which may have antibodies to the virus that causes COVID)	○	○	○	○
Treatment with blood thinner (medicines used to treat or prevent blood clots)	○	○	○	○
Treatment with antibiotics (medicines used to treat infections caused by bacteria)	○	○	○	○
Breathing tube / breathing machine (ventilator which acts like the lungs when a person can't breathe on their own)	○	○	○	○
Dialysis (treatment that helps clean the blood when the kidneys are hurt, or not working)	○	○	○	○
Other	○	○	○	○

What other treatments for COVID did [sname_you] get?

Special Health Care Needs Screener

ERROR! You must complete the visit form before you can start this form.

Date of form collection: _____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

Now we are going to ask some questions about whether [sname_you] [sv_has] any health care needs.

[sv_does_cap] [sname_you] currently need or use medicine prescribed by a doctor (other than vitamins)?

◯ Yes
◯ No

Is this because of ANY medical, behavioral, or other health condition?

◯ Yes
◯ No

Is this a condition that has lasted, or is expected to last, for at least 12 months?

◯ Yes
◯ No

[sv_does_cap] [sname_you] need or use more medical care, mental health, or educational services than is usual for most [sn_children] of the same age?

◯ Yes
◯ No

Is this because of ANY medical, behavioral, or other health condition?

◯ Yes
◯ No
◯ I do not want to answer

Is this a condition that has lasted, or is expected to last, for at least 12 months?

◯ Yes
◯ No

[sv_is_cap] [sname_you] limited or prevented in any way in [sp_their_your] ability to do the things most [sn_children] of the same age can do?

◯ Yes
◯ No

Is this because of ANY medical, behavioral, or other health condition?

◯ Yes
◯ No

Is this a condition that has lasted, or is expected to last, for at least 12 months?

◯ Yes
◯ No

[sv_does_cap] [sname_you] need or get special therapy, such as physical, occupational, or speech therapy?

◯ Yes
◯ No

Is this because of ANY medical, behavioral, or other health condition?

◯ Yes
◯ No

Is this a condition that has lasted, or is expected to last, for at least 12 months?

◯ Yes
◯ No

[sv_does_cap] [sname_you] child have any kind of emotional, developmental, or behavioral problem for which [sp_they_you] need or get treatment or counseling?

◯ Yes
◯ No

Is this a condition that has lasted, or is expected to last, for at least 12 months?

◯ Yes
◯ No

Has a doctor or other health care provider EVER told you that [sname_you] [sv_has]:

Asthma:_____ _____ _____ _____

Asthma:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

[sv_does_cap] [sname_you] currently have asthma?

[sv_does_cap] [sname_you] currently have asthma?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the asthma was caused by a COVID infection?

Do you think the asthma was caused by a COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the asthma was made worse by COVID?

Do you think the asthma was made worse by COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Cerebral Palsy:_____

Cerebral Palsy:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Diabetes:_____ _____ _____ _____ _____

Diabetes:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What type of diabetes?

What type of diabetes?

◯ Type 1
◯ Type 2
◯ I don't know
◯ I don't want to answer

[sv_does_cap] [sname_you] currently have diabetes?

[sv_does_cap] [sname_you] currently have diabetes?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the diabetes was caused by a COVID infection?

Do you think the diabetes was caused by a COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the diabetes was made worse by COVID?

Do you think the diabetes was made worse by COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Epilepsy or seizure disorder:_____ _____ _____ _____

Epilepsy or seizure disorder:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

[sv_does_cap] [sname_you] currently have epilepsy or a seizure disorder?

[sv_does_cap] [sname_you] currently have epilepsy or a seizure disorder?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think this was caused by a COVID infection?

Do you think this was caused by a COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think this was made worse by COVID?

Do you think this was made worse by COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Heart problem:_____ _____ _____ _____ _____ _____

Heart problem:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What type of heart problem?

What type of heart problem?

_____

[sv_was_cap] [sname_you] born with a heart problem?

[sv_was_cap] [sname_you] born with a heart problem?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

[sv_does_cap] [sname_you] currently have a heart problem?

[sv_does_cap] [sname_you] currently have a heart problem?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think this was caused by a COVID infection?

Do you think this was caused by a COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think this was made worse by COVID?

Do you think this was made worse by COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Frequent or severe headaches, including migraines:_____ _____ _____ _____

Frequent or severe headaches, including migraines:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

[sv_does_cap] [sname_you] currently have headaches?

[sv_does_cap] [sname_you] currently have headaches?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the headaches were caused by a COVID infection?

Do you think the headaches were caused by a COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the headaches were made worse by COVID?

Do you think the headaches were made worse by COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Tourette's syndrome or tics (movements of the face or other body parts that your child cannot control):_____
_____ _____ _____

Tourette's syndrome or tics:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

[sv_does_cap] [sname_you] currently have Tourette's syndrome or tics?

[sv_does_cap] [sname_you] currently have Tourette's syndrome or tics?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the Tourette's syndrome or tics were caused by a COVID infection?

Do you think the Tourette's syndrome or tics were caused by a COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the Tourette's syndrome or tics were made worse by COVID?

Do you think the Tourette's syndrome or tics were made worse by COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Anxiety (Feeling nervous or anxious):_____ _____ _____ _____

Anxiety (Feeling nervous or anxious):

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

[sv_does_cap] [sname_you] currently have anxiety?

[sv_does_cap] [sname_you] currently have anxiety?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the anxiety was caused by a COVID infection?

Do you think the anxiety was caused by a COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the anxiety was made worse by COVID?

Do you think the anxiety was made worse by COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Depression (Feeling very sad):_____ _____ _____ _____

Depression:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

[sv_does_cap] [sname_you] currently have depression?

[sv_does_cap] [sname_you] currently have depression?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the depression was caused by a COVID infection?

Do you think the depression was caused by a COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the depression was made worse by COVID?

Do you think the depression was made worse by COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Down syndrome:_____

Down syndrome:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Blood disorder (such as sickle cell disease, thalassemia, or hemophilia):_____ _____

Blood disorder:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Which blood disorder [sv_does] [sname_you] have?

Which blood disorder [sv_does] [sname_you] have?

_____

Cystic fibrosis:_____

Cystic fibrosis:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Other genetic or inherited condition:(Problem related to the genes. Genes are the part of your body that have DNA, the building blocks of the body that are passed on from parent to child)_____ _____

Other genetic or inherited condition:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Which genetic condition [sv_does] [sname_you] have?

Which genetic condition [sv_does] [sname_you] have?

_____

Has a doctor, other health care provider, or teacher ever told you that [sname_you] [sv_has]:

Problems with behavior?_____ _____ _____ _____

Problems with behavior:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

[sv_does_cap] [sname_you] currently have behavioral problems?

[sv_does_cap] [sname_you] currently have behavioral problems?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the problems were caused by a COVID infection?

Do you think the problems were caused by a COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the problems were made worse by COVID?

Do you think the problems were made worse by COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Developmental delay:(Being slower than other children in learning things like talking, building with blocks, walking, or running._____ _____ _____ _____

Developmental delay:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

[sv_does_cap] [sname_you] currently have developmental delay?

[sv_does_cap] [sname_you] currently have developmental delay?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the delay was caused by a COVID infection?

Do you think the delay was caused by a COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the delay was made worse by COVID?

Do you think the delay was made worse by COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Intellectual disability:_____

Intellectual disability:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Speech or other language disorder (Problems with talking or understanding words):_____ _____ _____ _____

Speech or other language disorder:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

[sv_does_cap] [sname_you] currently have a speech, or other language, disorder?

[sv_does_cap] [sname_you] currently have a speech, or other language, disorder?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the disorder was caused by a COVID infection?

Do you think the disorder was caused by a COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the disorder was made worse by COVID?

Do you think the disorder was made worse by COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Learning disability (problem with learning):_____ _____ _____ _____ _____

Learning disability:

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What type of learning disability or problem? Choose one or more of these.

What type of learning disability or problem? Choose one or more of these.

☐ Reading
☐ Math
☐ Writing

[sv_does_cap] [sname_you] currently have a learning disability?

[sv_does_cap] [sname_you] currently have a learning disability?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the disability was caused by a COVID infection?

Do you think the disability was caused by a COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the disability was made worse by COVID?

Do you think the disability was made worse by COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Autism or Autism Spectrum Disorder (ASD):_____ _____ _____ _____

Autism or autism spectrum disorder (ASD):

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

[sv_does_cap] [sname_you] currently have autism?

[sv_does_cap] [sname_you] currently have autism?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the autism was caused by a COVID infection?

Do you think the autism was caused by a COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the autism was made worse by COVID?

Do you think the autism was made worse by COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Attention Deficit Disorder or Attention Deficit/Hyperactivity Disorder, that is, ADD or ADHD?:_____ _____ _____ _____

Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD):

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

[sv_does_cap] [sname_you] currently have ADD or ADHD?

[sv_does_cap] [sname_you] currently have ADD or ADHD?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the ADD/ADHD was caused by a COVID infection?

Do you think the ADD/ADHD was caused by a COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the ADD/ADHD was made worse by COVID?

Do you think the ADD/ADHD was made worse by COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Eating disorders (like Anorexia or Binge eating disorder):_____ _____ _____ _____

Eating disorders (like Anorexia or Binge eating disorder):

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

[sv_does_cap] [sname_you] currently have an eating disorder?

[sv_does_cap] [sname_you] currently have an eating disorder?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the eating disorder was caused by a COVID infection?

Do you think the eating disorder was caused by a COVID infection?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Do you think the eating disorder was made worse by COVID?

Do you think the eating disorder was made worse by COVID?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

Please list any other health problems that [sname_you] currently [sv_has] that you have not already told us about.

Weekly COVID Infection History

ERROR! You must complete the visit form before you can start this form.

Date Weekly COVID Infection History form collected: _____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

Now we're going to ask about [sname_your_poss] experience with [sname_your_poss] MOST RECENT COVID infection.

[sv_does_cap] [sname_you] have any symptoms? Symptoms are signs of being sick, like having a fever or cough.

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

How bad, or severe, are [sname_your_poss] symptoms now?

◯ Very mild (slightly bad)
◯ Mild (a little bad)
◯ Moderate (medium bad)
◯ Severe (very bad)
◯ Extreme (extremely bad)
◯ Life-threatening (almost died from COVID)
◯ I don't know
◯ I do not want to answer

During the past [visit_2wks4wks], what kind of health care [sv_has] [sname_you] gotten for this COVID infection? Choose one or more of these.

☐ I was able to take care of [sname_myself] at home without talking with [sname_my_poss] doctor's office
☐ I took care of [sname_myself] at home and talked to [sname_my_poss] doctor by phone
☐ I took care of [sname_myself] at home and talked to [sname_my_poss] doctor using an online video visit
☐ [sname_i] was seen in person at [sp_their_my] regular doctor's office
☐ [sname_i] was seen at an urgent care facility (a place where you can walk in to get care right away without an appointment)
☐ [sname_i] was seen at the emergency department
☐ I don't know
☐ I do not want to answer

During the past [visit_2wks4wks], [sv_has] [sname_you] had to stay in the hospital (get admitted)?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What was the date [sname_you] had to stay in the hospital (got admitted)? _____

[sv_is_cap] [sname_you] still in the hospital?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What date [sv_was] [sname_you] sent home from the hospital? _____

During the past [visit_2wks4wks], [sv_has] [sname_you] had to stay in the [cih_picu_calcya]?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What was the date [sname_you] had to stay in the [cih_picu_calcya]? _____

[sv_is_cap] [sname_you] still in the [cih_picu_calcya]?

◯ Yes
◯ No
◯ I don't know
◯ I do not want to answer

What date [sv_was] [sname_you] sent home from the [cih_picu_calcya]? _____

During the past [visit_2wks4wks], [sv_has] [sname_you] gotten any of the following treatments?

	Yes	No	I don't know	I do not want to answer
Oxygen therapy (extra oxygen is given when a person's oxygen is low)	◯	◯	◯	◯
Intravenous fluids (giving fluids through a needle placed in a blood vessel)	◯	◯	◯	◯
Treatment with steroids (medicines that help decrease swelling (inflammation) in the body)	◯	◯	◯	◯
Treatment with hydroxychloroquine (medicine mostly used to treat malaria that has been studied for treating and preventing COVID)	◯	◯	◯	◯

Treatment with antiviral drug (medicines used to treat infections caused by a virus)	○	○	○	○
Treatment with monoclonal antibody (proteins made in a lab that act like the body's antibodies, to help the immune system find and kill germs)	○	○	○	○
Treatment with convalescent plasma (giving a person the plasma part of COVID survivors' blood, which may have antibodies to the virus that causes COVID)	○	○	○	○
Treatment with blood thinner (medicines used to treat or prevent blood clots)	○	○	○	○
Treatment with antibiotics (medicines used to treat infections caused by bacteria)	○	○	○	○
Breathing tube / breathing machine (ventilator which acts like the lungs when a person can't breathe on their own)	○	○	○	○
Dialysis (treatment that helps clean the blood when the kidneys are hurt, or not working)	○	○	○	○
Other, please explain:	○	○	○	○

What other treatments for COVID did [sname_you] get?