

ECHO Environmental influences on Child Health Outcomes A program supported by the NIH	COVID-19 Questionnaire – Child Self-Report Primary Version ECHO-wide Cohort Version 01.31 / June 8, 2020				Form C19-cPV Page 1 of 7	
	COHORT ID	SITE ID	PARTICIPANT ID	PIN	COHORT VISIT ID	FORM COMPLETED
_____	_____	_____	_____	_____	____ / ____ / ____ <i>mm dd yyyy</i>	
ECHO LIFE STAGE			RESPONDENT			
<input type="checkbox"/> ₀₁ Prenatal	<input type="checkbox"/> ₀₂ Perinatal	<input type="checkbox"/> ₀₁ Participant	<input type="checkbox"/> ₀₂ Biological Mother			
<input type="checkbox"/> ₀₃ Infancy	<input type="checkbox"/> ₀₄ Early Childhood	<input type="checkbox"/> ₀₃ Biological Father	<input type="checkbox"/> ₀₄ Other Respondent			
<input type="checkbox"/> ₀₅ Middle Childhood	<input type="checkbox"/> ₀₆ Adolescence			Code: __ __		

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

<p>INSTRUCTIONS:</p> <p><i>This form has 2 sections:</i></p> <ul style="list-style-type: none"> • Section A: COVID-19 Infection • Section B: Impacts of the COVID-19 Outbreak on You <p><i>These questions are about your experience with COVID-19, or the coronavirus. For each question, do the best you can to remember the details requested.</i></p>
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Section A. COVID-19 Infection

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

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

₀₁ Yes

₀₂ No

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

₀₁ Fever or chills

₀₂ Cough

₀₃ Shortness of breath

₀₄ Sore throat

₀₅ Headache

₀₆ Muscle or body aches

₀₇ Runny nose

₀₈ Fatigue or excessive sleepiness

₀₉ Diarrhea, nausea, or vomiting

₁₀ Loss of sense of smell or taste

₁₁ Itchy/red eyes

₁₂ None of the above → **skip to Section A, Question 3.**

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

₀₁ I was kept overnight in a hospital because a healthcare provider thought I had COVID-19

₀₂ I saw a healthcare provider in person, such as in a clinic, doctor's office, urgent care, or Emergency Room (ER)/Emergency Department (ED)

₀₃ I spoke to a healthcare provider over the phone, by email, or online

₀₄ I self-isolated or quarantined at home

₀₅ None of the above

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

₀₁ Have contact with someone who tested positive for COVID-19

₀₂ Have contact with someone who likely had COVID-19 (e.g., was not tested but had symptoms; was told by a healthcare provider that he/she likely had it)

₀₃ Travel to a different state or country (please specify: _____)

₀₄ None of the above

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

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

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

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

- ₀₁ Yes
- ₀₂ No → **Skip to Section B, Question 3**
- ₀₃ I am not enrolled in any school → **Skip to Section B, Question 3**

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

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

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

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

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

- ₀₁ Yes
- ₀₂ No

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

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

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

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

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

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

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

} → **Skip to Section B, Question 4**

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

- ₀₁ Yes
- ₀₂ No

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

4. Compared to before the COVID-19 outbreak, how much are you now doing the following:

	Less	Same amount	More
a. Eating	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
b. Sleeping	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
c. Physical activity	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
d. Spending time outside	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
e. Spending time with friends in-person	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
f. Spending time with friends remotely (e.g., online, social media, texting)	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
g. Spending time watching TV, playing video/computer games, or using social media for educational purposes, including school work	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃
h. Spending time watching TV, playing video/computer games, or using social media for non-educational purposes	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₃

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

- ₀₁ much less socially connected
- ₀₂ less socially connected
- ₀₃ slightly less socially connected
- ₀₄ slightly more socially connected
- ₀₅ more socially connected
- ₀₆ much more socially connected

Section B. Impacts of the COVID-19 Outbreak on You (continued)**6. What have you done to cope with your stress related to the COVID-19 outbreak? (*Mark all that apply*)**

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

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

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

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

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

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

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

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

Setting	Mode
<input type="checkbox"/> ₀₁ Clinic or site <input type="checkbox"/> ₀₂ Phone <input type="checkbox"/> ₀₃ Other location	<input type="checkbox"/> ₀₁ Self-administered <input type="checkbox"/> ₀₂ Staff-administered