DePaul Symptom Questionnaire-COVID

Axis 1

1. With which COVID variant were you infected? (Circle all that apply)
    a. Alpha
    b. Beta
    c. Gamma
    d. Delta
    e. Omicron
    f. Other (Please specify) _____
    g. Don't know

2. How were you diagnosed with COVID? (Circle all that apply)

    a. Positive PCR test
    b. Positive antigen result (rapid test)
    c. Positive antibody result (blood test)
    d. Positive result, but not sure which test
    e. Diagnosed by a doctor based on symptoms
    f. Self-diagnosed by symptoms

3. Have you been hospitalized for COVID?
    a. No
    b. Yes (How many days?) _____

4. While in the hospital, were you intubated for COVID?
    a. No
    b. Yes (How many days?) _____

5. Have you been vaccinated for COVID? (Circle one response)
    a. No
    b. One shot, please specify what type of vaccine _____
    c. Two shots, please specify what types of vaccine _____

6. Have you had any COVID booster shots? (Circle one response)
    a. No
    b. Yes, specify number and type _____

Axis 2

7. When did you begin having symptoms for COVID? (mm/dd/yyyy) _____

Axis 3

8. Has there been documented damage done to one or more organ areas due to the COVID infection? (For example, respiratory, nervous system, metabolic, cardiovascular, stroke,

gastrointestinal, arthritis, skin disorders, pulmonary embolism)

a. No
b. Yes (Please specify) _____

9. List any medical problems you had prior to being infected with COVID.

_____

Axis 4

10. Which statement best describes your fatigue/energy level over the last month? (Circle one response)

a. I am not able to work or do anything, and I am bedridden.
b. I can walk around the house, but I cannot do light housework.
c. I can do light housework, but I cannot work part-time.
d. I can only work part-time at work or on some family responsibilities.
e. I can work full time, but I have no energy left for anything else.
f. I can work full time and finish some family responsibilities, but I have no energy left for anything else.
g. I can do all work or family responsibilities without any problems with my energy.

11. Since the onset of your problems with fatigue/energy, have your symptoms caused a 50% or greater reduction in your activity level? (Circle one response)

a. No
b. Yes
c. Not having a problem with fatigue/energy

Axis 5

For each symptom below, please circle **one number for frequency** and **one number for severity**. Please complete the chart from left to right.

Frequency:	**Severity:**
Throughout the **past month**, **how often** have you had the symptoms listed below?	Throughout the **past month**, when a symptom below was present, **how severe** was it?
For each symptom listed below, circle a number from: **0 = none of the time** **1 = a little of the time** **2 = about half the time** **3 = most of the time** **4 = all of the time**	For each symptom listed below, circle a number from: **0 = symptom not present** **1 = mild** **2 = moderate** **3 = severe** **4 = very severe**

Symptom	**Frequency:**	**Severity:**

12. Fatigue/extreme tiredness	0 1 2 3 4	0 1 2 3 4
13. Cough	0 1 2 3 4	0 1 2 3 4
14. Loss of or change in smell and/or taste	0 1 2 3 4	0 1 2 3 4
15. Shortness of breath and/or trouble breathing	0 1 2 3 4	0 1 2 3 4
16. Chest pain	0 1 2 3 4	0 1 2 3 4
17. Nose congestion	0 1 2 3 4	0 1 2 3 4
18. Loss of hair	0 1 2 3 4	0 1 2 3 4
19. Headache	0 1 2 3 4	0 1 2 3 4
20. Bone and/or joint pain	0 1 2 3 4	0 1 2 3 4
21. Heavy legs and/or swelling of legs	0 1 2 3 4	0 1 2 3 4
22. Fever, chills, and/or sweating	0 1 2 3 4	0 1 2 3 4
23. Nerve problems (tremor, shaking, abnormal movements, numbness, tingling, burning, can't move part of body, new seizures)	0 1 2 3 4	0 1 2 3 4
24. Color changes in your skin such as red, white or purple	0 1 2 3 4	0 1 2 3 4
25. Vision problems (blurry, light sensitivity, difficult reading or focusing, floaters, flashing light)	0 1 2 3 4	0 1 2 3 4
26. Memory loss	0 1 2 3 4	0 1 2 3 4
27. Problems with hearing (hearing loss, ringing in ears)	0 1 2 3 4	0 1 2 3 4
28. Anxiety	0 1 2 3 4	0 1 2 3 4
29. Depression	0 1 2 3 4	0 1 2 3 4
30. Gastrointestinal (belly) symptoms (pain, feeling full or vomiting after eating, nausea, diarrhea, constipation)	0 1 2 3 4	0 1 2 3 4
31. Weight loss	0 1 2 3 4	0 1 2 3 4
32. Sore throat	0 1 2 3 4	0 1 2 3 4

33. Palpitations, racing heart, arrhythmia, and/or skipped beats	0 1 2 3 4	0 1 2 3 4
34. Bladder problems (incontinence, trouble passing urine or emptying bladder)	0 1 2 3 4	0 1 2 3 4
35. Sleep problems	0 1 2 3 4	0 1 2 3 4
36. Changes in desire for, comfort with or capacity for sex	0 1 2 3 4	0 1 2 3 4
37. Muscle aches	0 1 2 3 4	0 1 2 3 4
38. Ear pain	0 1 2 3 4	0 1 2 3 4
39. Dry eyes	0 1 2 3 4	0 1 2 3 4
40. Feeling faint, dizzy, and/or difficulty thinking soon after standing up from a sitting or lying position	0 1 2 3 4	0 1 2 3 4
41. Symptoms that get worse after physical or mental activities (also known as post-exertional malaise)	0 1 2 3 4	0 1 2 3 4
42. Skin rash	0 1 2 3 4	0 1 2 3 4
43. Difficulty thinking and/or concentrating	0 1 2 3 4	0 1 2 3 4
44. Pins and needles feeling	0 1 2 3 4	0 1 2 3 4
45. Stress	0 1 2 3 4	0 1 2 3 4
46. Sore tongue, mouth, and/or difficulty swallowing	0 1 2 3 4	0 1 2 3 4
47. Dry skin/peeling	0 1 2 3 4	0 1 2 3 4
48. Change in blood pressure	0 1 2 3 4	0 1 2 3 4
49. Gynecological symptoms (e.g., change in menstruation or menopause)	0 1 2 3 4	0 1 2 3 4

50. If you have or have had other symptoms, please list them below:_____

_____

[If measuring ME/CFS, use the following questions]

Do you have what has been referred to as chronic fatigue syndrome, Myalgic Encephalomyelitis, or Myalgic Encephalomyelitis/chronic fatigue syndrome? (Circle one response below)

a. No
b. Yes, already had this condition before I had COVID-19
c. Yes, I have this condition after I had COVID-19

DePaul Symptom Questionnaire-Short Form

For each symptom below, please circle **one number for frequency** and **one number for severity**. Please complete the chart from left to right.

Frequency:	**Severity:**
Throughout the **past 6 months**, **how often** have you had this symptom? For each symptom listed below, circle a number from: **0 = none of the time** **1 = a little of the time** **2 = about half the time** **3 = most of the time** **4 = all of the time**	Throughout the **past 6 months**, **how much** has this symptom bothered you? For each symptom listed below, circle a number from: **0 = symptom not present** **1 = mild** **2 = moderate** **3 = severe** **4 = very severe**

Symptom	**Frequency:**	**Severity:**
1. Fatigue/extreme tiredness	0 1 2 3 4	0 1 2 3 4
2. Next day soreness or fatigue after non-strenuous, everyday activities	0 1 2 3 4	0 1 2 3 4
3. Minimum exercise makes you physically tired	0 1 2 3 4	0 1 2 3 4
4. Feeling unrefreshed after you wake up in the morning	0 1 2 3 4	0 1 2 3 4
5. Pain or aching in your muscles	0 1 2 3 4	0 1 2 3 4
6. Bloating	0 1 2 3 4	0 1 2 3 4
7. Problems remembering things	0 1 2 3 4	0 1 2 3 4
8. Difficulty paying attention for a long period of time	0 1 2 3 4	0 1 2 3 4
9. Irritable bowel problems	0 1 2 3 4	0 1 2 3 4
10. Feeling unsteady on your feet, like you might fall	0 1 2 3 4	0 1 2 3 4
11. Cold limbs (e.g. arms, legs, hands)	0 1 2 3 4	0 1 2 3 4

12. Feeling hot or cold for no reason	0 1 2 3 4	0 1 2 3 4
13. Flu-like symptoms	0 1 2 3 4	0 1 2 3 4
14. Some smells, foods, medications, or chemicals make you feel sick	0 1 2 3 4	0 1 2 3 4