**INSTRUCTIONS:**

This questionnaire asks about COVID-19 symptoms that persist for more than 12 weeks. We ask everyone referred to the Long COVID Team to complete this questionnaire before and after being seen by the service. We will use this information to ensure you receive an appropriate intervention and to evaluate and improve the service. Only professionals directly involved in your care will look at your responses. This questionnaire will take around 10 minutes to complete. Please respond to all questions.

|  |  |  |
| --- | --- | --- |
| Full name: | Gender: F M | |
| Ethnicity: | Age (years): | |
| Date of birth: | Today’s date: | |
| Email for the Long COVID team to contact you on: | | |
| Do you consent for the Long COVID team to contact your GP: | | Yes No |
| GP name and address: | | |

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| --- | --- | --- |
|  | No | Yes |
| Do you consent for your anonymous questionnaire responses to be used for research purposes? |  |  |
| Please state the month / year that you contracted COVID 19: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Have you ever had a positive COVID-19 test? |  |  |
| Have you discussed all your Long COVID symptoms with your GP? |  |  |
| Have you been admitted to hospital for medical problems related to COVID-19? |  |  |
| Are you currently at work? |  |  |
| Are you at work but at risk of absence due to long-COVID? |  |  |
| Are you at work with adjustments to your hours / duties due to long-COVID? |  |  |
| Have you been redeployed to a new role due to long-COVID? |  |  |
| Have you attempted to return to work but been unsuccessful due to long-COVID? |  |  |
| If yes – please state how many attempts have you made \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Do you anticipate being able to return to work in the next 6-8 weeks? |  |  |
| Are you able to concentrate to manage a 45-minute appointment? |  |  |
| Do you have access to a computer/tablet/smartphone and confident to use *Attend Anywhere* or *Microsoft Teams* to attend 1:1 consultations or Online Long COVID Group sessions (instructions will be provided)? |  |  |

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| **How often have you experienced the following COVID-19 symptoms in the past 2 weeks:** | | | | | | | | | | |
|  | | Not at all | | 1-2 days a week | | 2-4 days a week | | 4-6 days a week | | Every day |
| Breathlessness | |  | |  | |  | |  | |  |
| Fever | |  | |  | |  | |  | |  |
| Persistent cough | |  | |  | |  | |  | |  |
| Loss of taste or smell | |  | |  | |  | |  | |  |
| Problems swallowing or chewing | |  | |  | |  | |  | |  |
| Problems with hearing or eyesight | |  | |  | |  | |  | |  |
| Fatigue (extreme tiredness) | |  | |  | |  | |  | |  |
| Headache | |  | |  | |  | |  | |  |
| Pain | |  | |  | |  | |  | |  |
| Physical weakness | |  | |  | |  | |  | |  |
| Sore throat | |  | |  | |  | |  | |  |
| Palpitations after activity | |  | |  | |  | |  | |  |
| Feeling sick/vomiting | |  | |  | |  | |  | |  |
| Poor appetite | |  | |  | |  | |  | |  |
| Difficulties controlling your bladder or bowels | |  | |  | |  | |  | |  |
| Weight loss | |  | |  | |  | |  | |  |
| Concentration or memory difficulties | |  | |  | |  | |  | |  |
| Problems speaking or communicating | |  | |  | |  | |  | |  |
| Dizziness | |  | |  | |  | |  | |  |
| Blackouts (fainting) | |  | |  | |  | |  | |  |
| Balance problems | |  | |  | |  | |  | |  |
| Sleep problems | |  | |  | |  | |  | |  |
| Other (please specify): | |  | |  | |  | |  | |  |
| **How often have your Long COVID symptoms affected the following life areas in the past 2 weeks:** | | | | | | | | | | |
|  | Not at all | | 1-2 days a week | | 2-4 days a week | | 4-6 days a week | | Every day | |
| Walking/getting around |  | |  | |  | |  | |  | |
| Housework/DIY/chores |  | |  | |  | |  | |  | |
| Washing/dressing |  | |  | |  | |  | |  | |
| Leisure/exercise |  | |  | |  | |  | |  | |
| Hobbies |  | |  | |  | |  | |  | |
| Relationships |  | |  | |  | |  | |  | |
| Other (please specify): |  | |  | |  | |  | |  | |

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| **Over the last 2 weeks, how often have you been bothered by the following problems?** | | | | |
|  | Not at all | Several days | More than half the days | Nearly every day |
| Little interest or pleasure in doing things |  |  |  |  |
| Feeling down, depressed or hopeless |  |  |  |  |
| Feeling nervous, anxious or on edge |  |  |  |  |
| Not being able to stop or control worrying |  |  |  |  |

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|  | Very poor | Poor | Neither poor nor good | Good | Very good |
| **How would you rate your quality of life?** |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Using the following 0-100 scale, please rate how your health is TODAY**: \_\_\_\_\_\_\_ /100 | | | | | | | | | | | | | | | | | | | | |
| 0 | 5 | 10 | 15 | 20 | 25 | 30 | 35 | 40 | 45 | 50 | 55 | 60 | 65 | 70 | 75 | 80 | 85 | 90 | 95 | 100 |

The worst health The best health

you can imagine you can imagine

|  |  |
| --- | --- |
| Under each heading, please tick the one box that best describes your health today | |
| **MOBILITY**  I have no problems in walking about  I have slight problems in walking about  I have moderate problems in walking about  I have severe problems in walking about  I am unable to walk about |  |
| **SELF-CARE**  I have no problems washing or dressing myself  I have slight problems washing or dressing myself  I have moderate problems washing or dressing myself  I have severe problems washing or dressing myself  I am unable to wash or dress myself |  |
| **USUAL ACTIVITIES** *(e.g. work, study, housework, family or leisure activities)*  I have no problems doing my usual activities  I have slight problems doing my usual activities  I have moderate problems doing my usual activities  I have severe problems doing my usual activities  I am unable to do my usual activities |  |
| **PAIN / DISCOMFORT**  I have no pain or discomfort  I have slight pain or discomfort  I have moderate pain or discomfort  I have severe pain or discomfort  I have extreme pain or discomfort |  |
| **ANXIETY / DEPRESSION**  I am not anxious or depressed  I am slightly anxious or depressed  I am moderately anxious or depressed  I am severely anxious or depressed  I am extremely anxious or depressed |  |

**Using the following 0-10 scales:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **How would you rate your understanding of your Long COVID symptoms?**  No knowledge Average knowledge Fully informed | | | | | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **How would you rate your confidence in managing your physical symptoms?**  No confidence Average confidence Fully confident | | | | | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|  |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **How would you rate your confidence in managing your cognitive / emotional symptoms?**  No confidence Average confidence Fully confident | | | | | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|  |  |  |  |  |  |  |  |  |  |  |

Please describe up to 3 difficulties that you hope the Long COVID Team can help you with:

|  |
| --- |
| 1. |
| 2. |
| 3. |