Appendix A

Survey Title: *Understanding long-term COVID-19 symptoms and outcomes among community—based populations*

This online survey is conducted by researchers from the University of Manitoba. The survey will ask about your experience with COVID-19 and if you or someone you care for such as your child experience(d) long-lasting symptoms as a result. You can answer this survey even if you did not have a positive COVID-19 test. The survey should take about 5-10 minutes to complete. Please complete the survey once for each person (i.e., yourself, your child).

The information collected in this survey will help us to better understand the number of people in Manitoba that had COVID-19, as well as the long-term symptoms of COVID-19. Patients under the age of 16 should complete this questionnaire with the help of a parent or legal decision maker.

Your participation is completely voluntary, and you may choose to skip questions.

The survey system will not record your e-mail address or IP (Internet protocol) address. Your responses will be anonymous i.e., nobody will know who responded, or the answers you provide. Your answers cannot be associated with any of your personal information (e.g., name, email address). The information from the survey responses will be grouped together with responses from other participants. The overall results of this survey will help the research team understand COVID-19 and long-lasting symptoms. This study has been approved by the University of Manitoba Health Research Ethics Board (HS25090 / H2021:279).

To begin the survey, please press the “Next” button.

By continuing and completing the survey you are consenting to participate.

(1) What is your postal code? _____

(2) Do you think that you or someone you care for had COVID-19?
   a. Yes, I had COVID-19 *(*Participant will skip to question 5)*
   b. Yes, my child *(*Participant answer question 3)*
   c. Yes, another person that I provide care *(*Participant answer question 3)*
   d. No *(*Participant will skip to question 20)*

Please answer the remaining questions thinking of the person you care for that had COVID-19.

(3) How old is the person that had COVID19?

(4) The person you care for that had COVID19 identifies as:

i. Male
ii. Female
iii. Non-binary
iv. Prefer not to answer

(5) When did you or someone you care for have COVID?
   a. Month/Year

(6) Was COVID-19 confirmed with a test (PCR or rapid test)?
   a. Yes
   b. No

(7) How many COVID-19 vaccines did you or the person who had COVID-19 have before having COVID-19?
   a. 0
   b. 1
   c. 2
   d. 3 or more

(8) Please tell us about the symptoms you or someone you cared for had **when you/they had** COVID-19:

Please rate the severity of each symptom:	Did not have	Mild	Moderate	Severe
Shortness of breath at rest				
Shortness of breath with activity				
Lingering cough or noisy breathing				
Chest pain at rest				
Chest pain with activity				
Dizziness, fainting or loss of consciousness				
Difficulty controlling the movement of your body				
Difficulty eating, drinking, or swallowing				
Issues with concentration, thinking or memory				
Headaches				
Extreme fatigue/exhaustion				
Experiencing anxiety				
Experiencing depression				
Difficulty sleeping				
Generalized muscle weakness				
Muscle or joint pain				
Issues with pain or discomfort				

Difficulty walking				
Other, explain:				

(9) Did you or someone you cared for have **any** physical or mental changes three months or more **after** having COVID-19?

a. Yes, symptoms for 3 or more months (Go to question 10)
b. No long-term symptoms (Go to question 13)
c. Unsure (Go to question 10)
d. Had COVID-19 less than 3 months ago (Go to question 13)

(10) Please tell us about the symptoms you or someone you cared for had for **3 or more months after** you/they had COVID-19:

Please rate the severity of each symptom:	Did not have	Mild	Moderate	Severe
Shortness of breath at rest				
Shortness of breath with activity				
Lingering cough or noisy breathing				
Chest pain at rest				
Chest pain with activity				
Dizziness, fainting or loss of consciousness				
Difficulty controlling the movement of your body				
Difficulty eating, drinking, or swallowing				
Issues with concentration, thinking or memory				
Headaches				
Extreme fatigue/exhaustion				
Experiencing anxiety				
Experiencing depression				
Difficulty sleeping				
Generalized muscle weakness				
Muscle or joint pain				
Issues with pain or discomfort				
Difficulty walking				
Other, explain:				

(11) Do you or someone you care for need additional help with day-to-day activities (such as walking, using the bathroom, bathing, changing) due to long-term COVID-19 symptoms (lasted 3 or more months)?

a. Yes

b. No

(12) Have you or someone you care for had to reduce time at work, school and personal activities due to long-term COVID-19 symptoms (lasted 3 or more months)?
   a. Yes
   b. No

(13) Have you or someone you care for seen a primary care provider (family doctor, nurse practitioner, walk in clinic) about your/their COVID-19 symptoms?
   a. Yes (Go to question 14)
   b. No (Go to question 15)

(14) Went to a primary care provider (family doctor, nurse practitioner, walk in clinic)
   a. When first got COVID-19
   b. About long-term symptoms (lasted 3 or more months)
   c. Both, about COVID-19 symptoms AND long-term symptoms

(15) Did not go to a primary care provider because:
   a. Did not need to
   b. Had trouble making an appointment
   c. Had difficulty getting to an appointment
   d. Prefer to explain in my own words: _____

(16) Have you or someone you care for seen a specialist because of long-term COVID-19 symptoms (lasted 3 or more months)?
   a. Yes
   b. No

(17) Have you or someone you care for seen a therapist because of long-term COVID-19 symptoms (lasted 3 or more months)? Select all that apply
   a. Yes, a physical therapist
   b. Yes, an occupational therapist
   c. Yes, a respiratory therapist
   d. Yes, a speech therapist
   e. No

(18) Have you or someone you care for visited the emergency department because of long-term COVID-19 symptoms (lasted 3 or more months)?
   a. Yes

b. No

(19) Have you or someone you care for been hospitalized because of COVID-19 symptoms?
   a. When I first got COVID-19
   b. About my long-term symptoms (lasted 3 or more months)
   c. No

Thank you for providing information about your experience with COVID-19. We have four more questions to help us understand who answered this survey:

(20) Do you identify as:
   a. Male
   b. Female
   c. Non-binary
   d. Prefer not to answer

(21) What is your age?

(22) What is your current level of education**?**
   a. No formal schooling
   b. Grade school (grade 1-8)
   c. Some high school, but did not graduate
   d. High school or high school equivalent certificate (grade 9-12)
   e. Completed registered Apprenticeship or other trades certificate or diploma
   f. College, CEGEP or other non-university certificate or diploma
   g. Undergraduate degree or some university
   h. Postgraduate degree or professional designation (e.g., Master's, PhD, MD)
   i. Do not know
   j. Prefer not to answer

(23) What is your current household income?
   a. Less than $30,000
   b. $30,000 - $100,000
   c. $100,000 or over
   d. Prefer not to answer

Thank you for your participation!