Baseline Covid-19 Stress Questionnaire

Thank you so much for helping us gather information on how the coronavirus that causes COVID-19 is affecting the lives of NYU CHES participants. During this national emergency, we would like to understand how the dramatic changes affecting our population may impact women's and children's health. To do so, we are asking our participants to complete this special COVID-19 questionnaire now (approximately 25 minutes), and then a series of very brief follow-up questionnaires approximately every two weeks (less than 5 minutes each). We appreciate your willingness to share your experiences during this difficult time.

Please enter today's date: _____

In order to make sure this questionnaire is correctly linked to your records in NYU CHES, please provide us with your name.

First Name _____

Last Name _____

Some families are relocating because of concerns about COVID-19. To make sure we have your most up-to-date information, please enter the address where you are currently staying :

House Number _____

Street Name _____

City _____

State _____

We'd like to begin with a few questions about your feelings.

1. On a scale of 1 to 10, where 1 means you have little or no stress and 10 means you have a great deal of stress, how would you rate your average level of stress before you were aware of COVID-19?

◯ 1 ◯ 2 ◯ 3 ◯ 4
◯ 5 ◯ 6 ◯ 7 ◯ 8
◯ 9 ◯ 10

2. On a scale of 1 to 10, where 1 means you have little or no stress and 10 means you have a great deal of stress, how would you rate your stress level right now?

◯ 1 ◯ 2 ◯ 3 ◯ 4
◯ 5 ◯ 6 ◯ 7 ◯ 8
◯ 9 ◯ 10

3. In the last two weeks, how often have you felt:

	never	almost never	sometimes	fairly often	very often
That you were unable to control the important things in your life?	○	○	○	○	○
Confident about your ability to handle your personal problems?	○	○	○	○	○
That things were going your way?	○	○	○	○	○
Difficulties were piling up so high that you could not overcome them?	○	○	○	○	○

4. In the last two weeks, how often have you:

	not at all	rarely	sometimes	often	very often
Had difficulty sleeping	○	○	○	○	○
Startled easily	○	○	○	○	○
Had angry outbursts	○	○	○	○	○
Felt a sense of time slowing down	○	○	○	○	○
Felt in a daze	○	○	○	○	○
Tried to avoid thoughts and feelings about COVID-19	○	○	○	○	○
Tried to avoid reading or watching information about COVID-19	○	○	○	○	○
Had distressing dreams about COVID-19	○	○	○	○	○
Been distressed when you saw something that reminded you of COVID-19	○	○	○	○	○

5. Please indicate the extent to which you agree with each of the following statements:

	stongly disagree	disagree	neutral	agree	strongly agree
I tend to bounce back quickly after hard times.	○	○	○	○	○
I have a hard time making it through stressful events.	○	○	○	○	○
It does not take me long to recover from a stressful event.	○	○	○	○	○
It is hard for me to snap back when something bad happens.	○	○	○	○	○
I usually come through difficult times with little trouble.	○	○	○	○	○
I tend to take a long time to get over set-backs in my life.	○	○	○	○	○

Now we'd like to ask you some health-related questions.

6. Are you currently pregnant? ◯ Yes ◯ No

7. Did you give birth on or after March 1, 2020? ◯ Yes ◯ No

7.5 When did you give birth? _____

8. Before giving birth, how worried were you about each of the following:

	not at all worried	slightly worried	somewhat worried	moderately worried	extremely worried	N/A
Fewer prenatal care visits (e.g., cancellations)	◯	◯	◯	◯	◯	◯
Contracting or having contracted COVID-19 while pregnant	◯	◯	◯	◯	◯	◯
Having pregnancy/birth complications due to contracting or having contracted COVID-19	◯	◯	◯	◯	◯	◯
Contracting COVID-19 in the hospital during delivery (check N/A if you were already diagnosed with COVID-19 before delivery)	◯	◯	◯	◯	◯	◯
Contracting COVID-19 after birth and not being able to care for my baby (check N/A if you were already diagnosed with COVID-19 before delivery)	◯	◯	◯	◯	◯	◯
Not having the support I would need during labor and delivery due to COVID-19 concerns	◯	◯	◯	◯	◯	◯
Being separated from my baby after delivery due to COVID-19 concerns	◯	◯	◯	◯	◯	◯
My baby contracting COVID-19 after birth	◯	◯	◯	◯	◯	◯
Future health problems for my child due to COVID-19 (either from being exposed during pregnancy or contracting it after birth)	◯	◯	◯	◯	◯	◯

Poor postnatal care for myself (e.g., being sent home early from the hospital, having fewer postnatal check-ups)	○	○	○	○	○	○
Changing my plans to breastfeed due to COVID-19 (e.g., having to pump and have someone else feed infant)	○	○	○	○	○	○
Family and friends would not be able to visit me and my baby	○	○	○	○	○	○
Family and friends would not be able to help me after the baby was born	○	○	○	○	○	○

9. When you were pregnant, did your prenatal care change with the increased spread of COVID-19? Please check all that apply.

- ☐ No change
- ☐ My care improved
- ☐ My care worsened
- ☐ I changed prenatal healthcare provider(s)
- ☐ I did not go to prenatal appointments because I was concerned about entering my healthcare provider's office
- ☐ My healthcare provider cancelled or reduced frequency of my prenatal visit(s)
- ☐ I had more prenatal visits
- ☐ The format of my prenatal care changed (e.g., from in-person to phone or telemedicine/video appointments)
- ☐ My healthcare provider directed me to self-isolate or quarantine
- ☐ Other

Other (please specify): _____

10. Did your birth plan change due to COVID-19? Please check all that apply.

- ☐ No change
- ☐ I changed hospitals
- ☐ I changed from hospital delivery to home birth
- ☐ I was induced because of COVID-19 infection
- ☐ I had a c-section because of COVID-19 infection
- ☐ My planned c-section or labor induction was changed
- ☐ One or more of my intended support people (e.g. partner, other family member doula) was not permitted to attend delivery
- ☐ Other

Other (please specify): _____

10.5 Was your experience following birth affected by COVID-19? Please check all that apply.

- ☐ I was separated from my baby immediately after delivery
- ☐ I had to pump breastmilk and have someone else bottle-feed my baby
- ☐ I changed from planning to breastfeed to feeding only formula
- ☐ I changed from planning to feed only formula to breastfeeding
- ☐ Family and friends were not able to visit me and my baby
- ☐ I was sent home early from the hospital
- ☐ My postnatal visits were cancelled or postponed
- ☐ Family and friends were not able to help me after the baby was born
- ☐ Other

Other (please specify): _____

10.6 In general, how stressed were you about changes to your prenatal, birth, and newborn experiences due to the COVID-19 outbreak?

- ◯ Not at all
- ◯ Mildly
- ◯ Moderately
- ◯ Extremely

11. Thinking about your current pregancy, how worried are you about each of the following:

	not all worried	slightly worried	somewhat worried	moderately worried	extremely worried	N/A
Fewer prenatal care visits (e.g., cancellations)	◯	◯	◯	◯	◯	◯
Contracting or having contracted COVID-19 while pregnant	◯	◯	◯	◯	◯	◯
Having pregnancy/birth complications due to contracting or having contracted COVID-19	◯	◯	◯	◯	◯	◯
Contracting COVID-19 in the hospital during delivery (check N/A if you have already been diagnosed with COVID-19)	◯	◯	◯	◯	◯	◯
Contracting COVID-19 after birth and not being able to care for my baby (check N/A if you have already been diagnosed with COVID-19)	◯	◯	◯	◯	◯	◯
Not having the support I will need during labor and delivery due to COVID-19 concerns	◯	◯	◯	◯	◯	◯

Being separated from my baby after delivery due to COVID-19 concerns	○	○	○	○	○	○
My baby contracting COVID-19 after birth	○	○	○	○	○	○
Future health problems for my child due to COVID-19	○	○	○	○	○	○
Poor postnatal care for myself (e.g., being sent home early from the hospital, having fewer postnatal check-ups)	○	○	○	○	○	○
Changing my plans to breastfeed due to COVID-19 (e.g., having to pump and have someone else feed infant)	○	○	○	○	○	○
Family and friends will not be able to visit me and my baby	○	○	○	○	○	○
Family and friends will not be able to help me after the baby is born	○	○	○	○	○	○

12. Has your prenatal care changed with the increased spread of COVID-19? Please check all that apply.

- ☐ No change
- ☐ My care has improved
- ☐ My care has worsened
- ☐ I have changed prenatal healthcare provider(s)
- ☐ I have not gone to prenatal appointments because I am concerned about entering my healthcare provider's office
- ☐ My healthcare provider has cancelled or reduced the frequency of my prenatal visit(s)
- ☐ I have had more prenatal visits
- ☐ The format of my prenatal care has changed (e.g., from in-person to phone or telemedicine/video appointments)
- ☐ My healthcare provider has directed me to self-isolate or quarantine
- ☐ Other

Other (please specify): _____

13. Has your birth plan changed in relation to COVID-19? Please check all that apply.

- ☐ No change
- ☐ I am changing hospitals
- ☐ I am changing from hospital delivery to home birth
- ☐ I will be induced because of COVID-19 infection
- ☐ I will have a c-section because of COVID-19 infection
- ☐ My planned c-section or labor induction is being changed
- ☐ One or more of my intended support people (e.g., partner, other family member, doula) will not be permitted to attend delivery
- ☐ Other

Other (please specify):	_____
13.5 In general, how stressed are you about changes to your prenatal care due to the COVID-19 outbreak? Please check all that apply.	◯ Not at all ◯ Mildly ◯ Moderately ◯ Extremely
14.1 Before the COVID-19 epidemic, were you thinking about becoming pregnant in the next 6-12 months?	◯ Yes ◯ No
14.2 Before the COVID-19 epidemic, were were you actively trying to become pregnant?	◯ Yes ◯ No
14.3 Are you still trying to become pregnant?	◯ Yes ◯ No
14.4 Do you plan to resume trying to become pregnant once the epidemic is over?	◯ Yes ◯ No ◯ Don't Know
14.5 Are you currently thinking about becoming pregnant in the next 6-12 months?	◯ Yes ◯ No
14.6 Are you actively trying to become pregnant right now?	◯ Yes ◯ No
14.9 How many children under age 18 live in your home?	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8

Please answer the following series of questions for each child under age 18 living in your home, beginning with the oldest.

15. Is this child enrolled in NYU CHES?	◯ Yes ◯ No
16. So that we can identify the child in our records, what is the child's first name?	_____

17. What is the child's age? Please select '0' in the months dropdown if child is less than 1 month old.

Age in years	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ 13 ◯ 14 ◯ 15 ◯ 16 ◯ 17 ◯ 18
OR	
Age in months	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12
18. Has a healthcare provider ever told you that the child had, or might have had, COVID-19?	◯ Yes ◯ No
19. Has the child had any of the following symptoms since March 1, 2020? Please check all that apply.	☐ Fever or chills ☐ Cough ☐ Shortness of breath ☐ Sore throat ☐ Headache ☐ Muscle or body aches ☐ Runny nose ☐ Fatigue or excessive sleepiness ☐ Diarrhea, nausea, or vomiting ☐ Loss of sense of smell or taste ☐ Itchy/red eyes ☐ None of the above

21. Did any of the following ever occur as a result of the child's symptoms? Please check all that apply.	☐ The child was hospitalized overnight for COVID-19 infection ☐ The child saw a healthcare provider in person, such as in a clinic, doctor's office, urgent care, or Emergency Room (ER)/Emergency Department (ED) ☐ You spoke to a healthcare provider about the child over the phone, by email, or online ☐ The child was isolated or quarantined at home because of COVID-19 symptoms/diagnosis ☐ None of the above
22. In the two weeks before symptoms occurred, did the child:	☐ Have contact with someone who tested positive for COVID-19? ☐ Have contact with someone who likely had COVID-19 (e.g., was not tested but had symptoms and/or was told by a healthcare provider that they probably had it)? ☐ Travel to a different state or country? ☐ None of the above
Please specify which state or country:	_____
23. Has the child had the nose swab test for COVID-19? Please check all that apply, including results if your child has been tested more than once.	☐ No, I never tried to get the child tested ☐ No, I tried to get the child tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
23a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
23b. What was the date of the child's most recent negative test? Please give your best estimate.	_____
23c. What was the date of the child's most recent positive test? Please give your best estimate.	_____
24. Has the child had a blood test to see whether they already had COVID-19 (serology)? Please check all that apply, including results if your child has been tested more than once.	☐ No, I never tried to get the child tested ☐ No, I tried to get the child tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
24a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
24b. What was the date of the child's most recent negative test? Please give your best estimate.	_____
24c. What was the date of the child's most recent positive test? Please give your best estimate.	_____

25. In what ways has the COVID-19 outbreak affected the child's overall healthcare? Please check all that apply.

- ☐ The child's healthcare provider(s) has been changed
- ☐ The child did not go to in-person healthcare appointments because I was concerned about the child entering the healthcare provider's office
- ☐ The child's healthcare provider cancelled appointments
- ☐ The child's healthcare provider changed to phone or online visits
- ☐ The child's healthcare provider told him/her to self-isolate or quarantine
- ☐ I am delaying/cancelling (or have delayed/cancelled) my child's next routine well visit
- ☐ None of these apply

26. Compared to before the epidemic, how much is the child now doing the following:

	Less	same amount	More
Eating	◯	◯	◯
Sleeping (number of hours)	◯	◯	◯
Nighttime waking	◯	◯	◯
Physical activity	◯	◯	◯
Spending time outside	◯	◯	◯
Screen time (TV, video/computer games, social media)	◯	◯	◯

26.5 Before the COVID-19 epidemic, did you have a child who was receiving Early Intervention (EI)?

- ◯ Yes
- ◯ No

26.6 Is your child currently receiving Early Intervention (EI) services?

- ◯ Yes, but the format has changed (e.g., to teletherapy)
- ◯ Yes, the format is the same as before the outbreak
- ◯ No

Child 2

15. Is this child enrolled in NYU CHES?

- ◯ Yes
- ◯ No

16. So that we can identify the child in our records, what is the child's first name?

_____

17. What is the child's age? Please select '0' in the months dropdown if child is less than 1 month old.

Age in years	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ 13 ◯ 14 ◯ 15 ◯ 16 ◯ 17 ◯ 18
OR	
Age in months	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12
18. Has a healthcare provider ever told you that the child had, or might have had, COVID-19?	◯ Yes ◯ No
19. Has the child had any of the following symptoms since March 1, 2020? Please check all that apply.	☐ Fever or chills ☐ Cough ☐ Shortness of breath ☐ Sore throat ☐ Headache ☐ Muscle or body aches ☐ Runny nose ☐ Fatigue or excessive sleepiness ☐ Diarrhea, nausea, or vomiting ☐ Loss of sense of smell or taste ☐ Itchy/red eyes ☐ None of the above

21. Did any of the following ever occur as a result of the child's symptoms? Please check all that apply.	☐ The child was hospitalized overnight for COVID-19 infection ☐ The child saw a healthcare provider in person, such as in a clinic, doctor's office, urgent care, or Emergency Room (ER)/Emergency Department (ED) ☐ You spoke to a healthcare provider about the child over the phone, by email, or online ☐ The child was isolated or quarantined at home because of COVID-19 symptoms/diagnosis ☐ None of the above
22. In the two weeks before symptoms occurred, did the child:	☐ Have contact with someone who tested positive for COVID-19? ☐ Have contact with someone who likely had COVID-19 (e.g., was not tested but had symptoms and/or was told by a healthcare provider that they probably had it)? ☐ Travel to a different state or country? ☐ None of the above
Please specify which state or country:	_____
23. Has the child had the nose swab test for COVID-19? Please check all that apply, including results if your child has been tested more than once.	☐ No, I never tried to get the child tested ☐ No, I tried to get the child tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
23a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
23b. What was the date of the child's most recent negative test? Please give your best estimate..	_____
23c. What was the date of the child's most recent positive test? Please give your best estimate.	_____
24. Has the child had a blood test to see whether they already had COVID-19 (serology)? Please check all that apply, including results if your child has been tested more than once.	☐ No, I never tried to get the child tested ☐ No, I tried to get the child tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
24a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
24b. What was the date of the child's most recent negative test? Please give your best estimate.	_____
24c. What was the date of the child's most recent positive test? Please give your best estimate.	_____

25. In what ways has the COVID-19 outbreak affected the child's overall healthcare? Please check all that apply.

- ☐ The child's healthcare provider(s) has been changed
- ☐ The child did not go to in-person healthcare appointments because I was concerned about the child entering the healthcare provider's office
- ☐ The child's healthcare provider cancelled appointments
- ☐ The child's healthcare provider changed to phone or online visits
- ☐ The child's healthcare provider told him/her to self-isolate or quarantine
- ☐ I am delaying/cancelling (or have delayed/cancelled) my child's next routine well visit
- ☐ None of the above

26. Compared to before the epidemic, how much is the child now doing the following:

	Less	same amount	More
Eating	◯	◯	◯
Sleeping (number of hours)	◯	◯	◯
Nighttime waking	◯	◯	◯
Physical activity	◯	◯	◯
Spending time outside	◯	◯	◯
Screen time (TV, video/computer games, social media)	◯	◯	◯

26.5 Before the COVID-19 epidemic, did you have a child who was receiving Early Intervention (EI)?

- ◯ Yes
- ◯ No

26.6 Is your child currently receiving Early Intervention (EI) services?

- ◯ Yes, but the format has changed (e.g., to teletherapy)
- ◯ Yes, the format is the same as before the outbreak
- ◯ No

Child 3

15. Is this child enrolled in NYU CHES?

- ◯ Yes
- ◯ No

16. So that we can identify the child in our records, what is the child's first name?

_____

17. What is the child's age? Please select '0' in the months dropdown if child is less than 1 month old.

Age in years	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ 13 ◯ 14 ◯ 15 ◯ 16 ◯ 17 ◯ 18
OR	
Age in months	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12
18. Has a healthcare provider ever told you that the child had, or might have had, COVID-19?	◯ Yes ◯ No
19. Has the child had any of the following symptoms since March 1, 2020? Please check all that apply.	☐ Fever or chills ☐ Cough ☐ Shortness of breath ☐ Sore throat ☐ Headache ☐ Muscle or body aches ☐ Runny nose ☐ Fatigue or excessive sleepiness ☐ Diarrhea, nausea, or vomiting ☐ Loss of sense of smell or taste ☐ Itchy/red eyes ☐ None of the above

21. Did any of the following ever occur as a result of the child's symptoms? Please check all that apply.	☐ The child was hospitalized overnight for COVID-19 infection ☐ The child saw a healthcare provider in person, such as in a clinic, doctor's office, urgent care, or Emergency Room (ER)/Emergency Department (ED) ☐ You spoke to a healthcare provider about the child over the phone, by email, or online ☐ The child was isolated or quarantined at home because of COVID-19 symptoms/diagnosis ☐ None of the above
22. In the two weeks before symptoms occurred, did the child:	☐ Have contact with someone who tested positive for COVID-19? ☐ Have contact with someone who likely had COVID-19 (e.g., was not tested but had symptoms and/or was told by a healthcare provider that they probably had it)? ☐ Travel to a different state or country? ☐ None of the above
Please specify which state or country:	_____
23. Has the child had the nose swab test for COVID-19? Please check all that apply, including results if your child has been tested more than once.	☐ No, I never tried to get the child tested ☐ No, I tried to get the child tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
23a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
23b. What was the date of the child's most recent negative test? Please give your best estimate.	_____
23c. What was the date of the child's most recent positive test? Please give your best estimate.	_____
24. Has the child had a blood test to see whether they already had COVID-19 (serology)? Please check all that apply, including results if your child has been tested more than once.	☐ No, I never tried to get the child tested ☐ No, I tried to get the child tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
24a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
24b. What was the date of the child's most recent negative test? Please give your best estimate.	_____
24c. What was the date of the child's most recent positive test? Please give your best estimate.	_____

25. In what ways has the COVID-19 outbreak affected the child's overall healthcare? Please check all that apply.

- ☐ The child's healthcare provider(s) has been changed
- ☐ The child did not go to in-person healthcare appointments because I was concerned about the child entering the healthcare provider's office
- ☐ The child's healthcare provider cancelled appointments
- ☐ The child's healthcare provider changed to phone or online visits
- ☐ The child's healthcare provider told him/her to self-isolate or quarantine
- ☐ I am delaying/cancelling (or have delayed/cancelled) my child's next routine well visit
- ☐ None of the above

26. Compared to before the epidemic, how much is the child now doing the following:

	Less	same amount	More
Eating	◯	◯	◯
Sleeping (number of hours)	◯	◯	◯
Nighttime waking	◯	◯	◯
Physical activity	◯	◯	◯
Spending time outside	◯	◯	◯
Screen time (TV, video/computer games, social media)	◯	◯	◯

26.5 Before the COVID-19 epidemic, did you have a child who was receiving Early Intervention (EI)?

- ◯ Yes
- ◯ No

26.6 Is your child currently receiving Early Intervention (EI) services?

- ◯ Yes, but the format has changed (e.g., to teletherapy)
- ◯ Yes, the format is the same as before the outbreak
- ◯ No

Child 4

15. Is this child enrolled in NYU CHES?

- ◯ Yes
- ◯ No

16. So that we can identify the child in our records, what is the child's first name?

_____

17. What is the child's age? Please select '0' in the months dropdown if child is less than 1 month old.

Age in years	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ 13 ◯ 14 ◯ 15 ◯ 16 ◯ 17 ◯ 18
OR	
Age in months	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12
18. Has a healthcare provider ever told you that the child had, or might have had, COVID-19?	◯ Yes ◯ No
19. Has the child had any of the following symptoms since March 1, 2020? Please check all that apply.	☐ Fever or chills ☐ Cough ☐ Shortness of breath ☐ Sore throat ☐ Headache ☐ Muscle or body aches ☐ Runny nose ☐ Fatigue or excessive sleepiness ☐ Diarrhea, nausea, or vomiting ☐ Loss of sense of smell or taste ☐ Itchy/red eyes ☐ None of the above

21. Did any of the following ever occur as a result of the child's symptoms? Please check all that apply.	☐ The child was hospitalized overnight for COVID-19 infection ☐ The child saw a healthcare provider in person, such as in a clinic, doctor's office, urgent care, or Emergency Room (ER)/Emergency Department (ED) ☐ You spoke to a healthcare provider about the child over the phone, by email, or online ☐ The child was isolated or quarantined at home because of COVID-19 symptoms/diagnosis ☐ None of the above
22. In the two weeks before symptoms occurred, did the child:	☐ Have contact with someone who tested positive for COVID-19? ☐ Have contact with someone who likely had COVID-19 (e.g., was not tested but had symptoms and/or was told by a healthcare provider that they probably had it)? ☐ Travel to a different state or country? ☐ None of the above
Please specify which state or country:	_____
23. Has the child had the nose swab test for COVID-19? Please check all that apply, including results if your child has been tested more than once.	☐ No, I never tried to get the child tested ☐ No, I tried to get the child tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
23a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
23b. What was the date of the child's most recent negative test? Please give your best estimate..	_____
23c. What was the date of the child's most recent positive test? Please give your best estimate.	_____
24. Has the child had a blood test to see whether they already had COVID-19 (serology)? Please check all that apply, including results if your child has been tested more than once.	☐ No, I never tried to get the child tested ☐ No, I tried to get the child tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
24a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
24b. What was the date of the child's most recent negative test? Please give your best estimate.	_____
24c. What was the date of the child's most recent positive test? Please give your best estimate.	_____

25. In what ways has the COVID-19 outbreak affected the child's overall healthcare? Please check all that apply.

- ☐ The child's healthcare provider(s) has been changed
- ☐ The child did not go to in-person healthcare appointments because I was concerned about the child entering the healthcare provider's office
- ☐ The child's healthcare provider cancelled appointments
- ☐ The child's healthcare provider changed to phone or online visits
- ☐ The child's healthcare provider told him/her to self-isolate or quarantine
- ☐ I am delaying/cancelling (or have delayed/cancelled) my child's next routine well visit
- ☐ None of the above

26. Compared to before the epidemic, how much is the child now doing the following:

	Less	same amount	More
Eating	◯	◯	◯
Sleeping (number of hours)	◯	◯	◯
Nighttime waking	◯	◯	◯
Physical activity	◯	◯	◯
Spending time outside	◯	◯	◯
Screen time (TV, video/computer games, social media)	◯	◯	◯

26.5 Before the COVID-19 epidemic, did you have a child who was receiving Early Intervention (EI)?

- ◯ Yes
- ◯ No

26.6 Is your child currently receiving Early Intervention (EI) services?

- ◯ Yes, but the format has changed (e.g., to teletherapy)
- ◯ Yes, the format is the same as before the outbreak
- ◯ No

Child 5

15. Is this child enrolled in NYU CHES?

- ◯ Yes
- ◯ No

16. So that we can identify the child in our records, what is the child's first name? _____

17. What is the child's age? Please select '0' in the months dropdown if child is less than 1 month old.

Age in years	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ 13 ◯ 14 ◯ 15 ◯ 16 ◯ 17 ◯ 18
OR	
Age in months	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12
18. Has a healthcare provider ever told you that the child had, or might have had, COVID-19?	◯ Yes ◯ No
19. Has the child had any of the following symptoms since March 1, 2020? Please check all that apply.	☐ Fever or chills ☐ Cough ☐ Shortness of breath ☐ Sore throat ☐ Headache ☐ Muscle or body aches ☐ Runny nose ☐ Fatigue or excessive sleepiness ☐ Diarrhea, nausea, or vomiting ☐ Loss of sense of smell or taste ☐ Itchy/red eyes ☐ None of the above

21. Did any of the following ever occur as a result of the child's symptoms? Please check all that apply.	☐ The child was hospitalized overnight for COVID-19 infection ☐ The child saw a healthcare provider in person, such as in a clinic, doctor's office, urgent care, or Emergency Room (ER)/Emergency Department (ED) ☐ You spoke to a healthcare provider about the child over the phone, by email, or online ☐ The child was isolated or quarantined at home because of COVID-19 symptoms/diagnosis ☐ None of the above
22. In the two weeks before symptoms occurred, did the child:	☐ Have contact with someone who tested positive for COVID-19? ☐ Have contact with someone who likely had COVID-19 (e.g., was not tested but had symptoms and/or was told by a healthcare provider that they probably had it)? ☐ Travel to a different state or country? ☐ None of the above
Please specify which state or country:	_____
23. Has the child had the nose swab test for COVID-19? Please check all that apply, including results if your child has been tested more than once.	☐ No, I never tried to get the child tested ☐ No, I tried to get the child tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
23a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
23b. What was the date of the child's most recent negative test? Please give your best estimate.	_____
23c. What was the date of the child's most recent positive test? Please give your best estimate.	_____
24. Has the child had a blood test to see whether they already had COVID-19 (serology)? Please check all that apply, including results if your child has been tested more than once.	☐ No, I never tried to get the child tested ☐ No, I tried to get the child tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
24a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
24b. What was the date of the child's most recent negative test? Please give your best estimate.	_____
24c. What was the date of the child's most recent positive test? Please give your best estimate.	_____

25. In what ways has the COVID-19 outbreak affected the child's overall healthcare? Please check all that apply.

- ☐ The child's healthcare provider(s) has been changed
- ☐ The child did not go to in-person healthcare appointments because I was concerned about the child entering the healthcare provider's office
- ☐ The child's healthcare provider cancelled appointments
- ☐ The child's healthcare provider changed to phone or online visits
- ☐ The child's healthcare provider told him/her to self-isolate or quarantine
- ☐ I am delaying/cancelling (or have delayed/cancelled) my child's next routine well visit
- ☐ None of the above

26. Compared to before the epidemic, how much is the child now doing the following:

	Less	same amount	More
Eating	◯	◯	◯
Sleeping (number of hours)	◯	◯	◯
Nighttime waking	◯	◯	◯
Physical activity	◯	◯	◯
Spending time outside	◯	◯	◯
Screen time (TV, video/computer games, social media)	◯	◯	◯

26.5 Before the COVID-19 epidemic, did you have a child who was receiving Early Intervention (EI)?

- ◯ Yes
- ◯ No

26.6 Is your child currently receiving Early Intervention (EI) services?

- ◯ Yes, but the format has changed (e.g., to teletherapy)
- ◯ Yes, the format is the same as before the outbreak
- ◯ No

Child 6

15. Is this child enrolled in NYU CHES?

- ◯ Yes
- ◯ No

16. So that we can identify the child in our records, what is the child's first name? _____

17. What is the child's age? Please select '0' in the months dropdown if child is less than 1 month old.

Age in years	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ 13 ◯ 14 ◯ 15 ◯ 16 ◯ 17 ◯ 18
OR	
Age in months	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12
18. Has a healthcare provider ever told you that the child had, or might have had, COVID-19?	◯ Yes ◯ No
19. Has the child had any of the following symptoms since March 1, 2020? Please check all that apply.	☐ Fever or chills ☐ Cough ☐ Shortness of breath ☐ Sore throat ☐ Headache ☐ Muscle or body aches ☐ Runny nose ☐ Fatigue or excessive sleepiness ☐ Diarrhea, nausea, or vomiting ☐ Loss of sense of smell or taste ☐ Itchy/red eyes ☐ None of the above

21. Did any of the following ever occur as a result of the child's symptoms? Please check all that apply.	☐ The child was hospitalized overnight for COVID-19 infection ☐ The child saw a healthcare provider in person, such as in a clinic, doctor's office, urgent care, or Emergency Room (ER)/Emergency Department (ED) ☐ You spoke to a healthcare provider about the child over the phone, by email, or online ☐ The child was isolated or quarantined at home because of COVID-19 symptoms/diagnosis ☐ None of the above
22. In the two weeks before symptoms occurred, did the child:	☐ Have contact with someone who tested positive for COVID-19? ☐ Have contact with someone who likely had COVID-19 (e.g., was not tested but had symptoms and/or was told by a healthcare provider that they probably had it)? ☐ Travel to a different state or country? ☐ None of the above
Please specify which state or country:	_____
23. Has the child had the nose swab test for COVID-19? Please check all that apply, including results if your child has been tested more than once.	☐ No, I never tried to get the child tested ☐ No, I tried to get the child tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
23a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
23b. What was the date of the child's most recent negative test? Please give your best estimate.	_____
23c. What was the date of the child's most recent positive test? Please give your best estimate..	_____
24. Has the child had a blood test to see whether they already had COVID-19 (serology)? Please check all that apply, including results if your child has been tested more than once.	☐ No, I never tried to get the child tested ☐ No, I tried to get the child tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
24a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
24b. What was the date of the child's most recent negative test? Please give your best estimate.	_____
24c. What was the date of the child's most recent positive test? Please give your best estimate.	_____

25. In what ways has the COVID-19 outbreak affected the child's overall healthcare? Please check all that apply.

- ☐ The child's healthcare provider(s) has been changed
- ☐ The child did not go to in-person healthcare appointments because I was concerned about the child entering the healthcare provider's office
- ☐ The child's healthcare provider cancelled appointments
- ☐ The child's healthcare provider changed to phone or online visits
- ☐ The child's healthcare provider told him/her to self-isolate or quarantine
- ☐ I am delaying/cancelling (or have delayed/cancelled) my child's next routine well visit
- ☐ None of the above

26. Compared to before the epidemic, how much is the child now doing the following:

	Less	same amount	More
Eating	◯	◯	◯
Sleeping (number of hours)	◯	◯	◯
Nighttime waking	◯	◯	◯
Physical activity	◯	◯	◯
Spending time outside	◯	◯	◯
Screen time (TV, video/computer games, social media)	◯	◯	◯

26.5 Before the COVID-19 epidemic, did you have a child who was receiving Early Intervention (EI)?

- ◯ Yes
- ◯ No

26.6 Is your child currently receiving Early Intervention (EI) services?

- ◯ Yes, but the format has changed (e.g., to teletherapy)
- ◯ Yes, the format is the same as before the outbreak
- ◯ No

Child 7

15. Is this child enrolled in NYU CHES?

- ◯ Yes
- ◯ No

16. So that we can identify the child in our records, what is the child's first name? _____

17. What is the child's age? Please select '0' in the months dropdown if child is less than 1 month old.

Age in years	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ 13 ◯ 14 ◯ 15 ◯ 16 ◯ 17 ◯ 18
OR	
Age in months	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12
18. Has a healthcare provider ever told you that the child had, or might have had, COVID-19?	◯ Yes ◯ No
19. Has the child had any of the following symptoms since March 1, 2020? Please check all that apply.	☐ Fever or chills ☐ Cough ☐ Shortness of breath ☐ Sore throat ☐ Headache ☐ Muscle or body aches ☐ Runny nose ☐ Fatigue or excessive sleepiness ☐ Diarrhea, nausea, or vomiting ☐ Loss of sense of smell or taste ☐ Itchy/red eyes ☐ None of the above

21. Did any of the following ever occur as a result of the child's symptoms? Please check all that apply.	☐ The child was hospitalized overnight for COVID-19 infection ☐ The child saw a healthcare provider in person, such as in a clinic, doctor's office, urgent care, or Emergency Room (ER)/Emergency Department (ED) ☐ You spoke to a healthcare provider about the child over the phone, by email, or online ☐ The child was isolated or quarantined at home because of COVID-19 symptoms/diagnosis ☐ None of the above
22. In the two weeks before symptoms occurred, did the child:	☐ Have contact with someone who tested positive for COVID-19? ☐ Have contact with someone who likely had COVID-19 (e.g., was not tested but had symptoms and/or was told by a healthcare provider that they probably had it)? ☐ Travel to a different state or country? ☐ None of the above
Please specify which state or country:	_____
23. Has the child had the nose swab test for COVID-19? Please check all that apply, including results if your child has been tested more than once.	☐ No, I never tried to get the child tested ☐ No, I tried to get the child tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
23a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
23b. What was the date of the child's most recent negative test? Please give your best estimate..	_____
23c. What was the date of the child's most recent positive test? Please give your best estimate.	_____
24. Has the child had a blood test to see whether they already had COVID-19 (serology)? Please check all that apply, including results if your child has been tested more than once.	☐ No, I never tried to get the child tested ☐ No, I tried to get the child tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
24a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
24b. What was the date of the child's most recent negative test? Please give your best estimate.	_____
24c. What was the date of the child's most recent positive test? Please give your best estimate.	_____

25. In what ways has the COVID-19 outbreak affected the child's overall healthcare? Please check all that apply.

- ☐ The child's healthcare provider(s) has been changed
- ☐ The child did not go to in-person healthcare appointments because I was concerned about the child entering the healthcare provider's office
- ☐ The child's healthcare provider cancelled appointments
- ☐ The child's healthcare provider changed to phone or online visits
- ☐ The child's healthcare provider told him/her to self-isolate or quarantine
- ☐ I am delaying/cancelling (or have delayed/cancelled) my child's next routine well visit
- ☐ None of the above

26. Compared to before the epidemic, how much is the child now doing the following:

	Less	same amount	More
Eating	◯	◯	◯
Sleeping (number of hours)	◯	◯	◯
Nighttime waking	◯	◯	◯
Physical activity	◯	◯	◯
Spending time outside	◯	◯	◯
Screen time (TV, video/computer games, social media)	◯	◯	◯

26.5 Before the COVID-19 epidemic, did you have a child who was receiving Early Intervention (EI)?

- ◯ Yes
- ◯ No

26.6 Is your child currently receiving Early Intervention (EI) services?

- ◯ Yes, but the format has changed (e.g., to teletherapy)
- ◯ Yes, the format is the same as before the outbreak
- ◯ No

Child 8

15. Is this child enrolled in NYU CHES?

- ◯ Yes
- ◯ No

16. So that we can identify the child in our records, what is the child's first name? _____

17. What is the child's age? Please select '0' in the months dropdown if child is less than 1 month old.

Age in years	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ 13 ◯ 14 ◯ 15 ◯ 16 ◯ 17 ◯ 18
OR	
Age in months	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12
18. Has a healthcare provider ever told you that the child had, or might have had, COVID-19?	◯ Yes ◯ No
19. Has the child had any of the following symptoms since March 1, 2020? Please check all that apply.	☐ Fever or chills ☐ Cough ☐ Shortness of breath ☐ Sore throat ☐ Headache ☐ Muscle or body aches ☐ Runny nose ☐ Fatigue or excessive sleepiness ☐ Diarrhea, nausea, or vomiting ☐ Loss of sense of smell or taste ☐ Itchy/red eyes ☐ None of the above

21. Did any of the following ever occur as a result of the child's symptoms? Please check all that apply.	☐ The child was hospitalized overnight for COVID-19 infection ☐ The child saw a healthcare provider in person, such as in a clinic, doctor's office, urgent care, or Emergency Room (ER)/Emergency Department (ED) ☐ You spoke to a healthcare provider about the child over the phone, by email, or online ☐ The child was isolated or quarantined at home because of COVID-19 symptoms/diagnosis ☐ None of the above
22. In the two weeks before symptoms occurred, did the child:	☐ Have contact with someone who tested positive for COVID-19? ☐ Have contact with someone who likely had COVID-19 (e.g., was not tested but had symptoms and/or was told by a healthcare provider that they probably had it)? ☐ Travel to a different state or country? ☐ None of the above
Please specify which state or country:	_____
23. Has the child had the nose swab test for COVID-19? Please check all that apply, including results if your child has been tested more than once.	☐ No, I never tried to get the child tested ☐ No, I tried to get the child tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
23a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
23b. What was the date of the child's most recent negative test? Please give your best estimate.	_____
23c. What was the date of the child's most recent positive test? Please give your best estimate.	_____
24. Has the child had a blood test to see whether they already had COVID-19 (serology)? Please check all that apply, including results if your child has been tested more than once.	☐ No, I never tried to get the child tested ☐ No, I tried to get the child tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
24a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
24b. What was the date of the child's most recent negative test? Please give your best estimate.	_____
24c. What was the date of the child's most recent positive test? Please give your best estimate.	_____

25. In what ways has the COVID-19 outbreak affected the child's overall healthcare? Please check all that apply.

- ☐ The child's healthcare provider(s) has been changed
- ☐ The child did not go to in-person healthcare appointments because I was concerned about the child entering the healthcare provider's office
- ☐ The child's healthcare provider cancelled appointments
- ☐ The child's healthcare provider changed to phone or online visits
- ☐ The child's healthcare provider told him/her to self-isolate or quarantine
- ☐ I am delaying/cancelling (or have delayed/cancelled) my child's next routine well visit
- ☐ None of the above

26. Compared to before the epidemic, how much is the child now doing the following:

	Less	same amount	More
Eating	◯	◯	◯
Sleeping (number of hours)	◯	◯	◯
Nighttime waking	◯	◯	◯
Physical activity	◯	◯	◯
Spending time outside	◯	◯	◯
Screen time (TV, video/computer games, social media)	◯	◯	◯

26.5 Before the COVID-19 epidemic, did you have a child who was receiving Early Intervention (EI)?

- ◯ Yes
- ◯ No

26.6 Is your child currently receiving Early Intervention (EI) services?

- ◯ Yes, but the format has changed (e.g., to teletherapy)
- ◯ Yes, the format is the same as before the outbreak
- ◯ No

27. Before the COVID-19 epidemic, did you have a child in childcare, daycare, or preschool?

- ◯ Yes
- ◯ No

28. How has the COVID-19 outbreak affected your regular childcare, daycare, or preschool? Please check all that apply.

- ☐ I had difficulty arranging for childcare
- ☐ I had to pay more for childcare
- ☐ My partner or I had to change our work schedule to care for our child(ren) ourselves
- ☐ My child's daycare/preschool closed completely because of the COVID-19 outbreak
- ☐ My child's daycare/preschool is open only for children of essential workers
- ☐ My child had to change to a different daycare/preschool
- ☐ My child's daycare/preschool is offering online learning
- ☐ My regular childcare/daycare has not been affected by the COVID-19 outbreak

28g1. Has your child's daycare/preschool provided free home internet access?

- ◯ Yes
- ◯ No

28g2. Has your child's daycare/preschool provided a free computer or tablet?	◯ Yes ◯ No
29. Has a healthcare provider ever told you that you had, or might have had, COVID-19?	◯ Yes ◯ No
30. Have you had any of the following symptoms since March 1, 2020? Please check all that apply.	☐ Fever or chills ☐ Cough ☐ Shortness of breath ☐ Sore throat ☐ Headache ☐ Muscle or body aches ☐ Runny nose ☐ Fatigue or excessive sleepiness ☐ Diarrhea, nausea, or vomiting ☐ Loss of smell or taste ☐ Itchy/red eyes ☐ None of the above
32. Did any of the following ever occur to you as a result of your symptoms? Please check all that apply.	☐ You were hospitalized overnight for COVID-19 infection ☐ You saw a healthcare provider in person such as in a clinic, doctor's office, urgent care, or Emergency Room (ER)/Emergency Department (ED) ☐ You spoke to a healthcare provider over the phone, by email, or online ☐ You self-isolated or quarantined at home because of COVID-19 symptoms/diagnosis ☐ None of the above
33. In the two weeks before symptoms occurred, did you:	☐ Have contact with someone who tested positive for COVID-19? ☐ Have contact with someone who likely had COVID-19? (e.g., was not tested but had symptoms and/or was told by a healthcare provider that they probably had it) ☐ Travel to a different state or country? ☐ None of the above
Please specify which state or country	_____
34. Have you ever had the nose swab test for COVID-19? Please check all that apply, including results if you have been tested more than once.	☐ No, I never tried to get tested ☐ No, I tried to get tested but was not able to ☐ Yes, and I am waiting for the results ☐ Yes, and the test result was negative ☐ Yes, and the test result was positive
34a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.	_____
34b. What was the date of your most recent negative test? Please give your best estimate.	_____
34c. What was the date of your most recent positive test? Please give your best estimate.	_____

35. Have you had a blood test to see whether you already had COVID-19 (serology)? Please check all that apply, including results if you have been tested more than once.

- ☐ No, I never tried to get tested
- ☐ No, I tried to get tested but was not able to
- ☐ Yes, and I am waiting for the results
- ☐ Yes, and the test result was negative
- ☐ Yes, and the test result was positive

35a. What was the date of the most recent test for which you are awaiting results? Please give your best estimate.

_____

35b. What was the date of your most recent negative test? Please give your best estimate.

_____

35c. What was the date of your most recent positive test? Please give your best estimate.

_____

36. In what ways has COVID-19 affected your overall healthcare? Please check all that apply.

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

37. Besides yourself, do other adults live in your household (partner, grandparent, etc.)?

- ◯ Yes
- ◯ No, I am the only adult in my household

38. Has another adult in your house had, or probably had, COVID-19?

- ◯ Yes
- ◯ No

41. Did any of the following ever occur to another adult in your house as a result of their symptoms? Please check all that apply.

- ☐ They were hospitalized overnight for COVID-19 infection
- ☐ They self-isolated or quarantined at home because of COVID-19 symptoms/diagnosis
- ☐ None of the above

COVID-19 is affecting many other aspects of people's lives besides health. Following are questions about other ways you may be affected.

44. Which of the following situations apply to you and your family? Please check all that currently apply.

- ☐ No activity restrictions/changes related to COVID-19
- ☐ Voluntary quarantine due to fear of exposure
- ☐ Voluntary quarantine due to suspected case in household
- ☐ Mandated self-isolation/quarantine by medical professional/government officials (not allowed to go out for any reason including groceries)
- ☐ Stay-at-home order by local government and/or employer urging people to stay home (e.g., can still take walks and socialize outdoors while maintaining social distancing)
- ☐ Shelter-in-place order by local government (i.e., only permitted outdoors for essential purposes)

45. How would you describe the money situation in your household before you were aware of COVID-19?	◯ Comfortable with extra ◯ Enough but no extra ◯ Have to cut back ◯ Cannot make ends meet
46. How would you describe the money situation in your household right now?	◯ Comfortable with extra ◯ Enough but no extra ◯ Have to cut back ◯ Cannot make ends meet

47. Which of the following changes in work life have you, your partner, or another person on whose income you depend experienced because of COVID-19. Please check all that apply and leave spaces blank if not applicable.

	self	partner	other person on whose income you depend
No change	☐	☐	☐
Permanent loss of job	☐	☐	☐
Temporary loss of job (i.e., furlough)	☐	☐	☐
New job	☐	☐	☐
Reduced hours	☐	☐	☐
Decreased pay	☐	☐	☐
Decreased job security	☐	☐	☐
Increased hours	☐	☐	☐
Increased responsibilites	☐	☐	☐
Job designated as an essential service	☐	☐	☐
Job causes increased risk of COVID-19 (e.g., healthcare workers, first reponders, etc.)	☐	☐	☐
Moved to remote work/work from home	☐	☐	☐
Had to lay off employees	☐	☐	☐
Did not have a paying job before the COVID-19 outbreak	☐	☐	☐

48. How concerned are you about the following in relation to the COVID-19 epidemic?

	not at all concerned	slightly concerned	somewhat concerned	moderately concerned	extremely concerned	N/A
Not being able to pay for basic needs (rent/mortgage, food, medicine, baby supplies, etc.)	◯	◯	◯	◯	◯	◯
Being evicted (check N/A if you are not a renter)	◯	◯	◯	◯	◯	◯

Availability of food	○	○	○	○	○	○
Availability of baby supplies (e.g., formula, diapers, wipes) (check N/A if you do not use these)	○	○	○	○	○	○
Availability of personal care products or household supplies	○	○	○	○	○	○
Losing my job (check N/A if you did not work prior to COVID-19)	○	○	○	○	○	○
My partner or someone I depend upon for income losing their job	○	○	○	○	○	○
Loss of health insurance (check N/A if you do not have health insurance)	○	○	○	○	○	○
I will get COVID-19 (check N/A if you have already been diagnosed with COVID-19)	○	○	○	○	○	○
My partner will get COVID-19 (check N/A if unpartnered or if your partner has already been diagnosed with COVID-19)	○	○	○	○	○	○
My unborn child will be exposed to COVID-19 (check N/A if not pregnant)	○	○	○	○	○	○
My child/children will get COVID-19 (check N/A if no children)	○	○	○	○	○	○
An elderly relative or close family friend will get COVID-19	○	○	○	○	○	○
Not being able to access medical care for myself or my family	○	○	○	○	○	○
Not being able to access mental health care for myself or my family	○	○	○	○	○	○
Not being productive at work because of having to supervise my child's homeschooling (check N/A if not working and homeschooling)	○	○	○	○	○	○
My child will fall behind in school (check N/A if no school-age children)	○	○	○	○	○	○

My child who is receiving Early Intervention (EI) will fail to progress or will lose skills (check N/A if no child receiving Early Intervention)	○	○	○	○	○	○
Increasing tension and/or violence in the home	○	○	○	○	○	○
Social distancing	○	○	○	○	○	○
Being quarantined	○	○	○	○	○	○
Impact on the community	○	○	○	○	○	○

Other (please specify): _____

49. COVID-19 has substantially changed people's daily lives. Compared to before the epidemic, how much are you now doing the following?

	Less	The same amount	More	I did not do this before the epidemic and still do not do it
Eating (quantity)	○	○	○	○
Eating home-cooked meals	○	○	○	○
Eating take-out/delivery foods	○	○	○	○
Sleeping	○	○	○	○
Physical activity	○	○	○	○
Spending time outdoors	○	○	○	○
Drinking alcohol	○	○	○	○
Smoking cigarettes	○	○	○	○
Vaping nicotine products (e.g., via e-cigarette or Juul)	○	○	○	○
Using marijuana in any form (e.g., smoking, vaping, eating)	○	○	○	○
Communicating with friends and family (e.g., by phone, text, or video)	○	○	○	○
Screen-time activities (e.g., television, video games, social media)	○	○	○	○
Volunteer work	○	○	○	○
Talking with medical provider(s)	○	○	○	○
Talking with mental healthcare provider(s) (e.g., therapist, psychologist, counselor)	○	○	○	○

49.5 Please indicate the extent to which you view the COVID-19 outbreak as having either a positive or negative impact on your life.	◯ Extremely negative ◯ Moderately negative ◯ Somewhat negative ◯ No impact ◯ Somewhat positive ◯ Moderately positive ◯ Extremely positive
50. Finally, is there something you are experiencing related to COVID-19 that we have not covered in this survey that you would like to tell us about?	◯ No, you've covered the major issues ◯ Yes
Please describe:	_____
Completed by staff?	◯ Yes

Thank you for completing your COVID baseline questionnaire! For completing this questionnaire, you are eligible to receive a $30 gift card! Please allow at least 2-4 weeks for your responses to be processed and gift cards to be sent out.

Would you like to receive an Amazon gift card electronically via email or would you like to receive a Bank of America physical gift card mailed to your address?	◯ I prefer an electronic gift card sent to my e-mail ◯ I prefer a physical gift card mailed to my address
Please confirm the email address you would like your e-gift card to be sent to	_____

Please confirm the address you would like your gift card to be sent to

Address	_____
City	_____
State	_____
Zip	_____

Thank you for your responses! If you have any questions, or experience any delays, please feel free to call us at 855-NYU-CHES (855-698-2437) or email us at NYUCHES@nyulangone.org