Symptom Burden Questionnaire™

LONG COVID

Version 1.0
September 2021

Name/ID Number:	
Date of Administration:	
Name of person completing the SBQ™-LC: (if by interview):	

The Symptom Burden Questionnaire™ for Long COVID (SBQ™-LC) asks for your views about your symptoms and their impact on daily life over **the last 7 days**.

It will take approximately 15-20 minutes to complete all the scales.

For each scale, please answer ALL the questions. Please rest and take breaks if needed.

Thank you for completing this questionnaire.

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BREATHING

These questions are about your BREATHING symptoms. For each question, please choose the response that best describes your experience over the last 7 days.

In the last 7 days, how severe was your **shortness of breath (difficulty breathing) when sitting** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **shortness of breath (difficulty breathing) when climbing a flight of stairs** at its worst?

****Response scale removed****

In the last 7 days, how severe was your **shortness of breath (difficulty breathing) when lying flat** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Please go to the next page

In the last 7 days, did you **wake up at night short of breath**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, was your **breathing faster than usual**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, how severe was the **tightness of your chest** at its worst?

****Response scale removed****

In the last 7 days, how severe was your **wheezing (noisy breathing)** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Breathing Scale Raw Score:	

PAIN

These questions are about your PAIN symptoms. For each question, please choose the response that best describes your experience over the last 7 days.

In the last 7 days, how severe was your **chest pain** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **pain on breathing** at its worst?

****Response scale removed****

In the last 7 days, how severe was your **shooting or stabbing pain** in any place on your body at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **aching or burning pain** in any place on your body at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Pain Scale Raw Score:	

CIRCULATION

These questions are about your CIRCULATION symptoms. For each question, please choose the response that best describes your experience over the last 7 days.

In the last 7 days, how severe were your **palpitations (feeling like your heart skipped a beat or a pounding heartbeat)** at their worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, did you **feel faint**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, how severe was your **dizziness on standing** at its worst?

*** *Response scale removed****

In the last 7 days, how severe was the **swelling of your legs and/or feet** at its worst?

In the last 7 days, did you have **cold hands/feet that lasted for longer or were colder than usua**l?

- ☐ 0 - No
- ☐ 1 - Yes

Circulation Scale Raw Score:	

FATIGUE

These questions are about your FATIGUE symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your **fatigue (feeling of physical or mental exhaustion that does not improve with rest)** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **low energy (being interested and wanting to do things but 1 - Yest having the energy**)?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **tiredness (need for sleep)** at its worst?

****Response scale removed****

In the last 7 days, how severe was the **worsening of your symptoms following simple physical or mental activities** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Fatigue Scale Raw Score:	

MEMORY, THINKING AND COMMUNICATION

These questions are about your MEMORY, THINKING, AND COMMUNCATION symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your **difficulty remembering things** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **memory loss** at its worst?

****Response scale removed****

In the last 7 days, how severe was your **brain fog (feeling sluggish, jet-lagged, or blanking out)** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how often did you **feel confused about what was happening around you**?

- ☐ 0 - Never
- ☐ 1 - Rarely
- ☐ 2 - Sometimes
- ☐ 3 - Always

In the last 7 days, how often did you have **difficulty concentrating**?

- ☐ 0 - Never
- ☐ 1 - Rarely
- ☐ 2 - Sometimes
- ☐ 3 - Always

Please go to the next page

In the last 7 days, how severe was your **difficulty planning** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **word-finding difficulty (unable to think of the word you want to say or write)** at its worst?

****Response scale removed****

In the last 7 days, how severe was your **difficulty understanding what others were saying** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **slurred speech** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **reading difficulty (not related to dyslexia)**?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Memory, Thinking & Communication Scale Raw Score:	

MOVEMENT

These questions are about your MOVEMENT symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your **tremor (uncontrollable shaking or trembling in part of your body)** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **balance difficulty** at its worst?

****Response scale removed****

In the last 7 days, how severe was your **difficulty with movement and coordination** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Movement Scale Raw Score:	

SLEEP

These questions are about your SLEEP symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how often did you have **problems falling asleep**?

- ☐ 0 - Never
- ☐ 1 - Rarely
- ☐ 2 - Sometimes
- ☐ 3 - Always

In the last 7 days, how often was your **sleep shorter than usual**?

****Response scale removed****

In the last 7 days, how often was your **sleep interrupted**?

- ☐ 0 - Never
- ☐ 1 - Rarely
- ☐ 2 - Sometimes
- ☐ 3 - Always

In the last 7 days, how often did you **sleep longer than usual**?

- ☐ 0 - Never
- ☐ 1 - Rarely
- ☐ 2 - Sometimes
- ☐ 3 - Always

Sleep Scale Raw Score:	

EARS, NOSE AND THROAT

These questions are about your EAR, NOSE, AND THROAT symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your **altered sense of smell (foods/objects smelling different to usual)** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **altered sense of taste (foods tasting different to usual)** at its worst?

****Response scale removed****

In the last 7 days, how severe was your **sneezing** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **stuffy or runny nose** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **sinus congestion (discomfort or feeling of 'fullness' around nose, cheeks, forehead, or around the eyes)** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Please go to the next page

In the last 7 days, how severe was your **production of mucus (phlegm)** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **cough** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **sore throat** at its worst?

****Response scale removed****

In the last 7 days, how severe was your **hoarse voice (change in your voice quality)** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, did you have **difficulty swallowing food or drink**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, how severe was your **earache (ear pain)** at its worst

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Please go to the next page

In the last 7 days, did you have ***new*** **hearing loss**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, how severe was your **tinnitus (noises or ringing sounds in your ears)** at its worst?

****Response scale removed****

In the last 7 days, how severe was your **sensitivity to sounds that were not a problem for others (everyday sounds were uncomfortably loud and/or painful) at its worst**?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Ears, Nose & Throat Scale Raw Score:	

STOMACH AND DIGESTION

These questions are about your STOMACH AND DIGESTION symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your **belly/tummy pain** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was the **bloating of your belly/tummy area** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **nausea (urge to vomit)** at its worst.

****Response scale removed****

In the last 7 days, how severe was your **indigestion and/or heartburn** at its worst.

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Please go to the next page

In the last 7 days, have you been worried about your **unplanned weight loss**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, have you been worried about your **unplanned weight gain**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, how severe was your **diarrhoea** at its worst?

**** Response scale removed ****

In the last 7 days, how severe was your **constipation (bowel movements happen less often than normal)** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Stomach & Digestion Scale Raw Score:	

MUSCLES AND JOINTS

These questions are about your MUSCLE AND JOINT symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your **muscle pain** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **muscle weakness** at its worst?

****Response scale removed****

In the last 7 days, how severe was your **muscle stiffness** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **joint pain** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **joint swelling** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Please go to the next page

In the last 7 days, how severe was your **joint stiffness** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **muscle twitching** at its worst?

****Response scale removed****

In the last 7 days, how severe was your **muscle cramping** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was the **tingling and numbness (pins and needles) in your arms and legs** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Muscle & Joints Scale Raw Score:	

MENTAL HEALTH AND WELLBEING

These questions are about your MENTAL HEALTH AND WELLBEING symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your **lack of interest in things around you at** its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **anxiety** at its worst?

****Response scale removed****

In the last 7 days, how severe were your **feelings of sadness and being miserable** at their worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, did you have thoughts about **harming yourself** in any way?*

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, how severe were your **mood swings** at their worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Please go to the next page

In the last 7 days, how severe was your **change in appetite** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how often did you feel **lonely or unsupported**?

****Response scale removed****

In the last 7 days, how often did you feel **hopeful about the future**?*

- ☐ 0 - Never
- ☐ 1 - Rarely
- ☐ 2 - Sometimes
- ☐ 3 - Always

In the last 7 days, did you feel **like the person you were before having COVID-19**?**

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ Not applicable

**Option for use in research studies involving control groups. Please see the SBQ™-LC user manual for further information.

Mental Health & Wellbeing Scale Raw Score:	

SKIN AND HAIR

These questions are about your SKIN AND HAIR symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your **dry skin** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **scaly skin** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **itchy skin** at its worst?

****Response scale removed****

In the last 7 days, did you have **purple-red spots on your feet**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, did you have a **rash**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, did you have **hives (welts or raised itchy patches of skin)**?

- ☐ 0 - No
- ☐ 1 - Yes

Please go to the next page

In the last 7 days, how severe was your **hair loss** at its worst?

****Response scale removed****

In the last 7 days, how severe were the **changes to your nails (ridging, pitting, discolouration, or brittle nails)** at their worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Skin & Hair Scale Raw Score:	

EYES

These questions are about your EYE symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, did you have **red or bloodshot eyes**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, did you have **dry eyes**?

- ☐ 0 – No
- ☐ 1 – Yes

In the last 7 days, did you have **itchy eyes**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, how severe was your **blurred vision and/or double vision (not related to wearing glasses)** at its worst?

****Response scale removed****

In the last 7 days, how often did you have **flashing lights and/or floaters (small dark shapes that float across your vision)**?

- ☐ 0 - Never
- ☐ 1 - Rarely
- ☐ 2 - Sometimes
- ☐ 3 - Always

In the last 7 days, how severe was your **sensitivity to light** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Please go to the next page

In last 7 days, did you have **watery eyes (excessive tears)**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, did you have a **feeling of pressure behind your eyes**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, how severe was the **feeling of pain behind your eyes** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how often did you have a **feeling of something rubbing against your eye when you blink (foreign body sensation)**?

- ☐ 0 - Never
- ☐ 1 - Rarely
- ☐ 2 - Sometimes
- ☐ 3 - Always

Eyes **Scale Raw Score:**	

FEMALE REPRODUCTIVE AND SEXUAL HEALTH

These questions are about your FEMALE REPRODUCTIVE AND SEXUAL HEALTH symptoms. Please answer ALL the questions thinking about your symptoms over the last 7 days.

In the last month, did you have **unusual changes to your menstrual period** (irregular, missed or unexpected period)?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ Not applicable

In the last month, was your **premenstrual syndrome (PMS) worse than usual**?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ Not applicable

In the last month, did you **pass blood clots during your period** more than usual?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ Not applicable

In the last 7 days, how severe was your **vaginal dryness** at its worst?

****Response scale removed****

In the last 7 days, how severe was your **vaginal discharge** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Please go to the next page

In the last 7 days, were you **worried about your ability to have an orgasm or climax**?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ Not applicable

In the last 7 days, how severe was your **decreased interest in sex** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Female Reproductive & Sexual Health Scale Raw Score:	

MALE REPRODUCTIVE AND SEXUAL HEALTH

These questions are about your MALE REPRODUCTIVE AND SEXUAL HEALTH symptoms. Please answer ALL the questions thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your **difficulty getting or keeping an erection** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, did you have **difficulty with ejaculation**?

****Response to reviewers****

In the last 7 days, did you have a **decreased interest in sex**?

- ☐ 0 - No
- ☐ 1 - Yes

Male Reproductive & Sexual Health Scale Raw Score:	

OTHER SYMPTOMS

These questions are about your OTHER SYMPTOMS. Please answer ALL the questions thinking about your symptoms over the last 7 days.

In the last 7 days, did you have a **fever**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, how often did you have **chills/shivering**?

****Response to reviewers****

In the last 7 days, how severe was your **sweating problem** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe were your **hot flushes** at their worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **aching all over the body** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Please go to the next page

In the last 7 days, how severe was the **swelling of your glands (lymph nodes)** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **vertigo (when everything around you was spinning enough to affect your balance)** at its worst?

Response scale removed

In the last 7 days, did you have **swelling of your face, lips, tongue, and/or throat**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, did you experience a **heightened reaction to known allergies**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, did you experience a **heightened reaction to new allergies**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, did you have **loss of control of urine (leakage)**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, did you have **difficulty passing urine**?

- ☐ 0 - No
- ☐ 1 - Yes

Please go to the next page

In the last 7 days, have you been **passing more urine than usual**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, how severe was your **increased thirst** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe were your **mouth ulcers** at their worst?

****Response scale has been removed****

In the last 7 days, did you experience a **worsening of known dental problems**?

- ☐ 0 - No
- ☐ 1 - Yes

In the last 7 days, how severe was your **dry mouth** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

In the last 7 days, how severe was your **headache** at its worst?

- ☐ 0 - None
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe

Other Symptoms Scale Raw Score:	

IMPACT ON DAILY LIFE

For EACH question, please select one answer that best describes how your symptoms have affected you in the last 7 days. Please answer ALL the questions.

In the last 7 days, have your symptoms affected your **ability to work, volunteer, go to school or take part in organised activities**?

- ☐ 0 - Not at all
- ☐ 1 - Very little
- ☐ 2 - Somewhat
- ☐ 3 - Severely

In the last 7 days, have your symptoms affected your ability to go **shopping**?

****Response to reviewers****

In the last 7 days, have your symptoms affected your ability to do **housework or light chores**?

- ☐ 0 - Not at all
- ☐ 1 - Very little
- ☐ 2 - Somewhat
- ☐ 3 - Severely

In the last 7 days, have your symptoms affected your ability to **move around easily**?

- ☐ 0 - Not at all
- ☐ 1 - Very little
- ☐ 2 - Somewhat
- ☐ 3 - Severely

Please go to the next page

In the last 7 days, have your symptoms affected your ability **to look after yourself (bathing and dressing)**?

- ☐ 0 - Not at all
- ☐ 1 - Very little
- ☐ 2 - Somewhat
- ☐ 3 - Severely

In the last 7 days, have your symptoms affected your **relationships with others (friends and family)**?

****Response to reviewers****

In the last 7 days, have your symptoms affected your **ability to socialise and interact with others**?

- ☐ 0 - Not at all
- ☐ 1 - Very little
- ☐ 2 - Somewhat
- ☐ 3 - Severely

In the last 7 days, have your symptoms affected your **ability to enjoy life**?

- ☐ 0 - Not at all
- ☐ 1 - Very little
- ☐ 2 - Somewhat
- ☐ 3 - Severely

Impact on Daily Life Scale Raw Score:	

Do you have any other symptoms you wish to report?

- ☐ 0 - No
- ☐ 1 - Yes

If **YES**, which other symptom(s) do you wish to report?

Symptom (*please describe each symptom on a new row*):	In the last 7 days, what was the **severity** of this symptom at its worst?		
For example: bruising	☐ 1 - Mild	☒ 2 - Moderate	☐ 3 - Severe
	☐ 1 - Mild	☐ 2 - Moderate	☐ 3 - Severe
	☐ 1 - Mild	☐ 2 - Moderate	☐ 3 - Severe
	☐ 1 - Mild	☐ 2 - Moderate	☐ 3 - Severe
	☐ 1 - Mild	☐ 2 - Moderate	☐ 3 - Severe
	☐ 1 - Mild	☐ 2 - Moderate	☐ 3 - Severe
	☐ 1 - Mild	☐ 2 - Moderate	☐ 3 - Severe
	☐ 1 - Mild	☐ 2 - Moderate	☐ 3 - Severe
	☐ 1 - Mild	☐ 2 - Moderate	☐ 3 - Severe
	☐ 1 - Mild	☐ 2 - Moderate	☐ 3 - Severe
	☐ 1 - Mild	☐ 2 - Moderate	☐ 3 - Severe

Thank you for taking the time to complete this questionnaire.

SBQ™-LC Score Sheet

To convert the raw scores for each scale to 0-100 linear scores, please use the conversion tables found in the appendix of the SBQ™-LC User Manual. Higher scores indicate greater symptom burden.

Scale	Scale Raw Score	0-100 Converted Score
Breathing		
Pain		
Circulation		
Fatigue		
Memory, Thinking, and Communication		
Movement		
Sleep		
Ears, Nose, and Throat		
Stomach and Digestion		
Muscles and Joints		
Mental Health		
Skin and Hair		
Eyes		
Reproductive and Sexual Health		
Other Symptoms		
Impact on Daily Life		

Symptom Burden Questionnaire™ for Long COVID (SBQ™-LC) Profile