Date: _____ Time point:_____ ID:_____

COVID-19 Adolescent Symptom & Psychological Experience Questionnaire (CASPE)

Thank you for participating in our research study. The questions below are about your experience during the Coronavirus or COVID-19 outbreak. Your responses to the following questions are very important to us. Please read each question carefully and answer as accurately as you can.

EXPERIENCE RELATED TO COVID-19

1. Overall, how much has the COVID-19 outbreak, and the resulting changes to daily life, affected your life in a negative way?

- No at all
- A little
- Somewhat
- A lot
- A great deal

2. What event or change to daily life has been the most negative? (check up to three)

- Worried about someone who has or has had the virus
- Having to stay at home
- Not seeing friends in person
- Thinking about how many people are dying because of the virus
- Not going to school
- Spending more time with family
- Increased stress or disorientation from not having a schedule
- Not having access to things I need (i.e., food, products)

3. Overall, how much has the COVID-19 outbreak, and the resulting changes to daily life, affected your life in a positive way?

- Not at all
- A little
- Somewhat
- A lot
- A great deal

4. What event or change to daily life has been the most positive? (check all that apply)

- Reduced amount of schoolwork or no schoolwork
- Less stress/pressure from school and activities
- More time to relax
- Getting to do things I don't usually have time for (i.e., art, music, writing, cooking)
- Getting more recreational time on the phone/computer (i.e., texting, social media)
- Getting to watch more TV/movies
- More time to exercise or go outside
- Getting more sleep
- Spending more time with family
- Spending more time with my pet(s)
- Not having to have unwanted interactions with other kids at school
- Feeling like I have more control in creating my own schedule

Date: _____ Time point:_____ ID:_____

5. Have you been tested for COVID-19?

- Yes
- No

5.a If yes, was the COVID-19 test positive?

- Yes
- No

5.b If yes, please indicate the date. Your response should be in this format: **mm/dd/yyyy**

_____

6. In past 4 weeks, have you had any flu like symptoms (e.g., fever, dry cough, shortness of breath)?

- Yes
  - If yes, which symptoms have you had? (select all that apply)
    - Fever
    - Dry Cough
    - Fatigue
    - Sputum Production (thick mucus from lungs)
    - Sore Throat
    - Shortness of Breath
    - Headache
    - Muscle or Joint Pain
    - Diarrhea
    - Nausea or Vomiting
    - Chills
    - Nasal Congestion
    - Red/itchy eye
- No

7. Have you been hospitalized because of COVID-19?

- Yes
  7.a. If yes, for how long? _____
- No

8. Have you been quarantined at home (i.e. isolated from other people for 14 days or more) because you had or were exposed to COVID-19?

- Yes

  8.a. If yes, for how long? _____
- No

9. Do you know anyone who has tested positive for COVID-19?
   9.a. Yes (please select who):

   - Select who [drop-down menu]:
     - Mother
     - Father
     - Sibling(s)

  - Grandparent(s)
  - Aunt/Uncle(s)
  - Cousin(s)
  - Friend/Classmate(s)
  - Neighbor
  - Teacher
  - Friend's Family Member
  - Other:
- No

10. How many people in your household have or have had COVID-19?

- Number:_____
- None

11. Has anyone in your household or extended family (i.e., grandparent, uncle/aunt, cousin) been hospitalized because they had COVID-19?

11.a. Yes (please select who):

  - Select who [drop-down menu]:
    - Mother
    - Father
    - Sibling(s)
    - Grandparent(s)
    - Aunt/Uncle(s)
    - Cousin(s)
    - Other:
- No

12. Has anyone in your household or extended family (i.e., grandparent, uncle/aunt, cousin) been quarantined at home (i.e. isolated from other people for 14 days or more) because they had or were exposed to COVID-19?

12.a. Yes (please select who):

Select who [drop-down menu]:
- Mother
- Father
- Sibling(s)
- Grandparent(s)
- Aunt/Uncle(s)
- Cousin(s)
- Other:

- No

13. Has anyone in your household or extended family (i.e., grandparent, uncle/aunt, cousin) died because they had COVID-19?

13.a. Yes (please select who):

  - Select who [drop-down menu]:
    - Mother
    - Father
    - Sibling(s)
    - Grandparent(s)

  - Aunt/Uncle(s)
  - Cousin(s)
  - Other:
- No

14. Have any of your friends (or their family members) had COVID-19?

- Yes (who): _____
- No

15. Have any of your friends (or their family members) been hospitalized because of COVID-19?

- Yes (who): _____
- No

16. Have any of your friends (or their family members) been quarantined at home (i.e. isolated from other people for 14 days or more) because they had or were exposed to COVID-19?

- Yes (who): _____
- No

17. On what date did your school close because of the COVID-19 outbreak? Your response should be in this format: **mm/dd/yyyy**

_____

18. Following school closures, how did you continue with schoolwork? (consider after Spring Break if schools closed during that time)

- School sent printed packets and/or recommendations
- School sent on-line assignments to complete without virtual classes
- School organized on-line classes
- Signed-up for a different on-line academic program
- There has been no school since then
- Already in cyber school
- Other (Please specify): _____