Data Collection Worksheet

Please Note: The Data Collection Worksheet (DCW) is a tool to aid integration of a PhenX protocol into a study. The PhenX DCW is not designed to be a data collection instrument. Investigators will need to decide the best way to collect data for the PhenX protocol in their study. Variables captured in the DCW, along with variable names and unique PhenX variable identifiers, are included in the PhenX Data Dictionary (DD) files.

Headaches

1. Have you experienced any new **HEADACHES OR RELATED ISSUES** since the start of your COVID-19 illness?

[ ] Yes

[ ] No

2. Which of the following symptoms have you experienced since the start of your COVID-19 illness?

[ ] Headaches, at the base of the skull

[ ] Headaches, in the temples

[ ] Headaches, behind the eyes

[ ] Headaches, diffuse (entire brain)

[ ] Headaches/pain after mental exertion

[ ] Headaches, other: _____

[ ] Sensation of brain warmth/"on fire"

[ ] Sensation of brain pressure

[ ] Migraines

[ ] Stiff neck

[ ] None of the above

3. When did you experience these symptoms?
Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7
Headaches and related symptoms	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Sense of Smell and Taste

4. Have you experienced any changes to your **SENSE OF SMELL OR TASTE** since the start of your COVID-19 illness?

[ ] Yes

[ ] No

5. Which of the following symptoms have you experienced since the start of your COVID-19 illness? *

[ ] Loss of smell

[ ] Phantom smells (imagining/hallucinating smells - smelling things that arent there)

[ ] Heightened sense of smell

[ ] Altered sense of smell

[ ] Loss of taste

[ ] Phantom taste (imagining/hallucinating tastes - tasting things when theres nothing in your mouth)

[ ] Heightened sense of taste

[ ] Altered sense of taste

[ ] None of the above

6. When did you experience these symptoms?
Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7
Changes to sense of smell and taste	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

7. If you had phantom tastes, please describe them:

_____

8. If you had phantom smells, please describe them:

_____

Tremors and Vibrating Sensations

9. Have you experienced any **TREMOR OR VIBRATION SENTATIONS** since the start of your COVID-19 illness?

Tremor: Involuntary, rhythmic muscle contraction leading to shaking movements in one or more parts of the body

Vibration sensation: A buzzing feeling, when you feel like your muscles, fingers, or legs are vibrating or shaking inside, but you dont see the movement

[ ] Yes

[ ] No

10. Which of the following symptoms have you experienced since the start of your COVID-19 illness?

Please specify the location on your body in the text box. If multiple locations, please separate them with a comma (i.e. leg, torso, hand).

[ ] Tremors: _____

[ ] Vibrating sensations: _____

11. When did you experience these symptoms?

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7
Tremors	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Vibrating sensations	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

12. Please use this space to describe examples of your tremors or body vibration/shaking during your illness.

Please do not include any identifying information (such as name or location).

_____

Weakness, numbness, tingling, coldness, and other sensations

13. Which of the following **NEUROLOGICAL SENSATION SYMPTOMS** have you experienced since the start of your COVID-19 illness, if any?

Please specify the location on your body in the text box. If multiple locations, please separate them with a comma (i.e. hand, leg, foot).

[ ] Skin sensations: burning, tingling, or itchiness without rash

[ ] Numbness/loss of sensation: _____

[ ] Numbness/weakness on one side of the body only

[ ] Coldness: _____

[ ] Tingling/prickling/pins and needles sensation: _____

[ ] Electrical zaps/electrical shock sensation: _____

[ ] Facial paralysis (please indicate where on face was paralyzed): _____

[ ] Sensation of facial pressure/numbness, left side

[ ] Sensation of facial pressure/numbness, right side

[ ] Sensation of facial pressure/numbness, other: _____

[ ] Weakness: _____

[ ] None of the above

14. When did you experience these symptoms?

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7
All neurological sensations	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Protocol source: https://www.phenxtoolkit.org/protocols/view/992003