PhenX Toolkit

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.

Sleeping Issues

1. Have you experienced any **SLEEPING ISSUES** since the start of your COVID-19 illness?

[ ] Yes
[ ] No

1a. Which of the following sleeping issues have you experienced since the start of your COVID-19 illness?

[ ] Lucid dreams (dreams where you are aware you are dreaming or have some control over what you dream about)
[ ] Vivid dreams
[ ] Nightmares
[ ] Insomnia
[ ] Night sweats
[ ] Restless leg syndrome
[ ] Awakened by feeling like you couldn't breathe
[ ] Sleep apnea
[ ] Other _____

1b. 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
Insomnia										
Sleep apnea										
All the										

other sleeping symptoms										

2. If you have/had insomnia, which best describes the type of insomnia?

[ ] Difficulty falling asleep
[ ] Waking up early in the morning
[ ] Waking up several times during the night
[ ] None of the above

3. What is causing/caused your insomnia?

[ ] Pain
[ ] Sensitivity to outside light/noise
[ ] Other physical discomfort
[ ] Anxiety/depression/racing thoughts
[ ] Difficulty breathing
[ ] A sensation of adrenaline/energy
[ ] A sensation like the virus was keeping me awake
[ ] Other _____

Hallucinations

4. Have you experienced any **HALLUCINATIONS** (visual, hearing, or touch) since the start of your COVID-19 illness?

[ ] Yes
[ ] No

4a. Which of the following hallucinations have you experienced since the start of your COVID-19 illness?

[ ] Visual (seeing) Hallucinations
[ ] Auditory (hearing) Hallucinations
[ ] Tactile (touch) Hallucinations
[ ] Hallucinations, other _____

4b. 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
Hallucinations										

Protocol source: https://www.phenxtoolkit.org/protocols/view/992006