CanPATH COVID-19 QUESTIONNAIRE (V6)

DEMOGRAPHIC INFORMATION

How old are you?
_____ Years

What is your sex at birth?
0 Male
1 Female

Which best describes your current gender identity?
0 Male
1 Female
2 Indigenous or other cultural gender minority (e.g., two-spirit)
3 Other (e.g., gender fluid, non-binary)
8 Prefer not to answer

What gender do you currently live as in your day-to-day life?
0 Male
1 Female
2 Sometimes male, sometimes female
3 Something other than male or female
8 Prefer not to answer

How many adults (age 18 or older) including yourself are currently living in your household?
Value
9 Don't know

How many children (under 18 years of age) are currently living in your household?
Value
9 Don't know

Are you currently pregnant?
1 Yes
0 No
9 Don't know

> **[IF YES] In what week are you?**
> Value (Weeks)

What are the first three digits of your current residential Postal Code?
First three digits of Postal Code:_____
8 Prefer not to answer
9 Don't know

COVID-19 DIAGNOSES

Have you used an online screening or self-assessment tool to determine if you might have and/or should be tested for COVID-19?
1 Yes
0 No
8 Prefer not to answer

[IF YES] What was the source of the self-assessment tool? (check all that apply)
1 Provincial health authority or government
2 Employer
3 Other

As of today, have you been tested for COVID-19?
1 Yes
2 No – because I haven't experienced any symptoms
3 No – I have experienced one or more symptoms (for example, a cough, mild fever, muscle soreness, fatigue) but have not been tested
4 No – I have experienced symptoms but I do not met the testing criteria in my province
8 Prefer not to answer

[IF YES] What was the result of your COVID-19 test?
0 Negative
1 Positive
8 Prefer not to answer
9 Don't know or have not received results yet

What was the date of your COVID-19 test?
Value (DD-MM-YYYY)
8 Prefer not to answer
9 Don't know

What was the date that you received the results?
Value (DD-MM-YYYY)
8 Prefer not to answer
9 Don't know

Do you suspect you have/had an undiagnosed case of COVID-19?
1 Yes
0 No
9 Don't know

<u>COVID-19 SYMPTOMS</u>

Did you have a fever in the past month?
1 Yes
0 No
9 Don't know

[IF YES] How long did it last (if you had more than one fever answer this question for the longest)?
Value (hours or days)
9 Don't know

What was the highest temperature recorded?
Value (°C or ^{0}F)
7 I did not take my temperature
9 Don't know

Since January 1, 2020, have you experienced any of the following symptoms (check all that apply):

	0 No	1 Mild	2 Severe	9 Don't know
Dry Cough				
Wet cough (Cough that produces mucus)				
Runny nose				
Sinus pain				
Ear pain				
Sore throat				
Hoarseness				
Shortness of breath or difficulty breathing				
Headache				
Fatigue				

	0 No	1 Mild	2 Severe	9 Don't know
General muscle and/or joint aches and pains				
Chills or shivering				
Loss of taste				
Loss of sense of smell				
Pneumonia				
Diarrhea				
Loss of appetite				
Nausea				
Vomiting				
Other – text box				

[IF YES TO ANY SYMPTOMS] Do you feel back to normal?
1 Completely
2 Mostly
3 A bit
4 Not really
5 Not at all

[IF YES to 1,2] If you feel back to normal, how long were you sick for?
Number of days
9 Don't know

Do you still have difficulty with any of the following (select all that apply)

	0 No	1 Mild	2 Severe	9 Don't know
Fever				
Dry Cough				
Wet cough (Cough that produces mucus)				
Runny nose				
Sinus pain				
Ear pain				
Sore throat				
Hoarseness				
Shortness of breath or				

	0 No	1 Mild	2 Severe	9 Don’t know
difficulty breathing				
Headache				
Fatigue				
General muscle and/or joint aches and pains				
Chills or shivering				
Loss of taste				
Loss of sense of smell				
Pneumonia				
Diarrhea				
Loss of appetite				
Nausea				
Vomiting				

COVID-19 - CARE/HOSPITAL RELATED INFORMATION

The following questions are only presented to participants with a positive test result for Covid-19.

Were you hospitalized because of COVID-19?

1 Yes
0 No
9 Don't know

[IF YES] What date did you get admitted to the hospital?

DD-MM-YYYY
9 Don't know

How many days were you in the hospital?

Number of days
9 Don't know

Were you admitted to an intensive care unit?

1 Yes
0 No
9 Don't know

[IF YES] How long did you stay in the intensive care unit?

Number of days
9 Don’t know

Did you have a chest X-ray or CT scan?
1 Yes
0 No
9 Don't know

Did you require mechanical ventilation for Covid-19?
1 Yes
0 No
9 Don't know

[IF YES] Number of days mechanical ventilation was received
Number of days
9 Don't know

What was the reason for ending hospitalization?
0 Discharge (recovered)
1 Other/Unknown

Have you experienced complications related to hospitalization after you were discharged?
1 Yes
0 No
9 Don't know

[IF YES] Did you require further treatment or hospitalization?
1 Yes
0 No
9 Don't know

Did you receive treatment with any experimental therapies for COVID-19?
0 Yes
1 No
8 Prefer not to answer
9 Don't know

[IF YES] Do you know which experimental therapies you received?
1 Remdesivir
2 Chloroquine/Hydroxychloroquine
3 Lopinavir-Ritonavir
4 Tocilizumab
5 Colchicine
6 Other – text box
8 Prefer not to answer
9 Don't know

Were the therapies described above prescribed to you by a clinician for COVID-19 (prevention or treatment)?
1 Yes
0 No
8 Prefer not to answer
9 Don't know

COVID-19 – EXPOSURE

Did you travel after January 1, 2020?
1 Yes
0 No
9 Don't know

[IF YES] If you travelled after January 1, 2020 how far did you travel? (Check all that apply - if you had multiple trips, please list details for your most recent trip for domestic and/or international travel, if applicable).
1 Domestic (within province)
2 Domestic (outside of province but within Canada)
If yes, where did you travel to? (text box)
What were your dates of travel? (DD MM YYYY to DD MM YYYY)
9 Don't know
3 International
If yes, where did you travel? (text box)
What were your dates of travel? (DD MM YYYY to DD MM YYYY)
9 Don't know

4 Travel on a cruise ship
If yes, what were your dates of travel? (DD MM YYYY to DD MM YYYY)
9 Don't know

Have you been in the same room as a person who was told by a physician that he or she has COVID-19?
1 Yes
0 No
9 Don't Know

[IF YES] On which date did you have first contact with this person?
DD MM YYYY
9 Don't know

Since January 1st, 2020, have you been in the same room as a person who has had new onset fever, severe fatigue, shortness of breath, dry cough, muscle pain or increased sputum production?
1 Yes
0 No
9 Don't Know

> **[IF YES] On which date did you have first contact with this person?**
> DD MM YYYY
> 9 Don't know

Have you been in the same room as a person who has returned from a trip since January 1st, 2020 from outside of Canada?
1 Yes
0 No
9 Don't Know

> **[IF YES] On which date did you have first contact with this person?**
> DD MM YYYY
> 9 Don't know

Have you been in any large public gatherings of greater than 250 people (such as a concert) since January 1st 2020?
1 Yes
0 No
9 Don't know

Have you limited your contact with other people?
1 Yes
0 No
8 Prefer not to answer
9 Don't know

What prevention measures have you put in place? (select all that apply)
I did not go to work
I did not visit with people outside my household
I isolated myself from members of my household
I did not go to bars and restaurants
I did not go to large gatherings of people, such as concerts
I wore masks when going out in public
I wore gloves when going out in public
I kept a distance of 6 feet from other people when out in public
I practiced good hand hygiene (washed hands often and well)
Other (text box)

None

Did you regularly take public transit before the pandemic?
1 Yes
0 No
8 Prefer not to answer
9 Don't Know

> **[IF YES] Have you continued to take public transit after your province declared a public health emergency?**
> 1 Yes
> 0 No
> 8 Prefer not to answer
> 9 Don't know

For the next two questions, please use the following definitions:
Self-isolation*: stayed at home other than essential errands or exercise,* ***did not leave the house for work,*** *no symptoms or positive test*
Quarantine*: did not leave your house or yard due to possible exposure, symptoms, or positive test*

To date, have you self-isolated during the COVID-19 pandemic?
1 Yes
0 No
8 Prefer not to answer
9 Don't know

> **[IF YES] If you are still in self-isolation, how many weeks has it been?**
> Weeks
> 9 Don't know
>
> **How many people (adults and children) living in your home are in self-isolation with you?**
> Number of people
> 9 Don't know

To date, have you or anyone in your household been in quarantine during the COVID-19 pandemic?
1 Yes
0 No
8 Prefer not to answer
9 Don't know

> **[IF YES] If you or anyone in your household is still in quarantine, how long has it been?**

Weeks
9 Don’t know

If you have completed quarantine, how long was it?
Weeks
9 Don’t know

[IF YES] Did/Do you have someone to help meet your immediate needs (e.g. food, medicine, etc.)?
1 Yes
0 No
9 Don’t know

Are you working as a medical professional (physician/ nurse/ hospital employee/ first responder/ pharmacist with patient exposure)?
1 Yes
0 No
8 Prefer not to answer
9 Don't know

Are you working as an essential service provider (grocery store attendant, public transit etc.)?
1 Yes
0 No
8 Prefer not to answer
9 Don’t know

What do you think is the likelihood of you contracting COVID-19?
1 Very likely
2 Somewhat likely
3 Not very likely
4 Not likely at all
9 Do not know

What do you think is the likelihood that you will survive COVID-19 if you get infected?
1 Very likely
2 Somewhat likely
3 Not very likely
4 Not likely at all
9 Do not know

RISK FACTORS

At the present time, do you smoke cigarettes daily, occasionally, or not at all?
1 Daily (At least one cigarette every day for the past 30 days)
2 Occasionally (At least one cigarette in the past 30 days, but not every day)

3 Not at all (You did not smoke at all in the past 30 days)

[IF YES to Daily or Occasionally] Has your smoking changed since the start of the pandemic?
0 No
1 Yes – smoking more than before
2 Yes – smoking less than before
9 Don't know

Vaping products have many names, such as: e-cigarettes, vape pens, vapes, mods, tanks, and e-hookahs. They may also be known by various brand names.
Have you ever tried an electronic cigarette, also known as an e-cigarette?
1 Yes
0 No
9 Don't know

[IF YES] In the past 30 days did you use an e-cigarette?
1 Yes
0 No
9 Don't know

Has your use of e-cigarettes changed since the start of the pandemic?
0 No
1 Yes – using more than before
2 Yes – using less than before
9 Don't know

Have you used cannabis in the past 12 months?
1 Yes
0 No
8 Prefer not to answer
9 Don't know

[IF YES] In the past 12 months, have you used cannabis for any of the following?
1 Non-medical purposes only
2 Medical purposes only, either with or without a medical document
3 Both medical and non-medical purposes
8 Prefer not to answer
9 Don't know

In the past 12 months, which of the following methods did you use most often?
1 Smoked
2 Vaporized
3 Consumed in food or drink

4 Other
8 Prefer not to answer
9 Don’t know

Has your use of cannabis changed since the start of the pandemic?
0 No
1 Yes – using more often than before
2 Yes – using less often than before
9 Don’t know

On average, over the last year, how often did you drink alcohol?
7 6 to 7 times a week
6 4 to 5 times a week
5 2 to 3 times a week
4 Once a week
3 2 to 3 times a month
2 About once a month
1 Less than once a month
0 Never
9 Don't know

[If any option other than 0 and 9 chosen] **Has your alcohol consumption changed since the start of the pandemic?**
0 No
1 Yes – drinking alcohol more often than before
2 Yes – drinking alcohol less often than before
9 Don’t know

What is your blood type?
1 A
2 B
3 AB
4 O
8 Prefer not to answer
9 Don’t Know

Compared to before the pandemic, have you changed your level of physical activity during the COVID-19 pandemic?
1 Substantially increased
2 Somewhat increased
3 No change
4 Somewhat decreased
5 Substantially decreased

MEDICAL CONDITIONS

Has a doctor ever told you that you had a cancer or a malignancy of any kind?
1 Yes
0 No
9 Don't know

[IF YES] What type of cancer was it? (check all that apply)

Type of Cancer	Are you currently undergoing treatment?
Breast	1 Yes 0 No 9 Don't know
Colon	1 Yes 0 No 9 Don't know
Leukemia	1 Yes 0 No 9 Don't know
Lung and bronchus	1 Yes 0 No 9 Don't know
Lymphoma (Hodgkin Lymphoma)	1 Yes 0 No 9 Don't know
Lymphoma (non-Hodgkin Lymphoma)	1 Yes 0 No 9 Don't know
Pancreatic	1 Yes 0 No 9 Don't know
Prostate	1 Yes 0 No 9 Don't know
Rectum	1 Yes 0 No 9 Don't know
Skin (Melanoma)	1 Yes 0 No 9 Don't know
Skin (Non-Melanoma)	1 Yes 0 No

Type of Cancer	Are you currently undergoing treatment?
	9 Don't know
Thyroid	1 Yes 0 No 9 Don't know
Uterus	1 Yes 0 No 9 Don't know
Other: _____	1 Yes 0 No 9 Don't know

Has a doctor ever told you that you had any of the following conditions? (check all that apply)

Condition	Diagnosed	Are you currently being treated?
Diabetes	1 Yes 0 No 9 Don't know If yes, which type of diabetes was it?	
	Type 1 diabetes	1 Yes 0 No 9 Don't know
	Type 2 diabetes	1 Yes 0 No 9 Don't know
Heart and circulatory conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	High blood pressure (hypertension, not including during pregnancy)	1 Yes 0 No 9 Don't know
	Heart attack (myocardial infarction)	1 Yes 0 No 9 Don't know
	Heart failure	1 Yes 0 No 9 Don't know

Condition	Diagnosed	Are you currently being treated?
	Atherosclerosis / Coronary heart disease (including angioplasty or stents)	1 Yes 0 No 9 Don't know
	Atrial fibrillation	1 Yes 0 No 9 Don't know
	Angina	1 Yes 0 No 9 Don't know
	Valvular heart disease (e.g. aortic stenosis, mitral valve prolapse)	1 Yes 0 No 9 Don't know
	Other: _____	1 Yes 0 No 9 Don't know
Respiratory system conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	Asthma	1 Yes 0 No 9 Don't know
	Chronic obstructive pulmonary disease (COPD)	1 Yes 0 No 9 Don't know
	Interstitial lung disease	1 Yes 0 No 9 Don't know
	Chronic bronchitis	1 Yes 0 No 9 Don't know
	Cystic fibrosis	1 Yes 0 No 9 Don't know
	Emphysema	1 Yes 0 No 9 Don't know
	Sleep apnea	1 Yes 0 No 9 Don't know

Condition	Diagnosed	Are you currently being treated?
	Other: _____	1 Yes 0 No 9 Don't know
Gastrointestinal conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	Crohn's disease	1 Yes 0 No 9 Don't know
	Ulcerative colitis	1 Yes 0 No 9 Don't know
	Irritable bowel syndrome	1 Yes 0 No 9 Don't know
	Celiac disease	1 Yes 0 No 9 Don't know
	Other: _____	1 Yes 0 No 9 Don't know
Liver or pancreas conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	Liver cirrhosis	1 Yes 0 No 9 Don't know
	Chronic hepatitis	1 Yes 0 No 9 Don't know
	Fatty liver (NAFLD- non-alcoholic fatty liver disease / NASH – nonalcoholic steatohepatitis)	1 Yes 0 No 9 Don't know
	Other: _____	1 Yes 0 No 9 Don't know

Condition	Diagnosed	Are you currently being treated?
Renal disease / kidney failure conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	Acute renal failure	1 Yes 0 No 9 Don't know
	Chronic renal failure	1 Yes 0 No 9 Don't know
	Other: _____	1 Yes 0 No 9 Don't know
Neurological conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	Thrombotic stroke	1 Yes 0 No 9 Don't know
	Hemorrhagic stroke	1 Yes 0 No 9 Don't know
	Multiple sclerosis	1 Yes 0 No 9 Don't know
	Other: _____	1 Yes 0 No 9 Don't know
Bone and joint conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	Arthritis Which type(s) of arthritis was it?	

Condition	Diagnosed	Are you currently being treated?
	Rheumatoid arthritis Osteoarthritis Don't know Other (please specify): _____	1 Yes 0 No 9 Don't know
	Lupus	1 Yes 0 No 9 Don't know
	Fibromyalgia	1 Yes 0 No 9 Don't know
	Other: _____	1 Yes 0 No 9 Don't know
Skin conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	Eczema	1 Yes 0 No 9 Don't know
	Psoriasis	1 Yes 0 No 9 Don't know
	Scleroderma	1 Yes 0 No 9 Don't know
	Other: _____	1 Yes 0 No 9 Don't know
Immune system conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	HIV	1 Yes 0 No 9 Don't know
	A weakened or compromised immune system such as Severe Combined	1 Yes 0 No 9 Don't know

Condition	Diagnosed	Are you currently being treated?
	Immunodeficiency)	
	Hashimoto's thyroiditis, Sjögren's syndrome, or Ankylosing spondylitis	1 Yes 0 No 9 Don't know
	Other: _____	1 Yes 0 No 9 Don't know
Other	1 Yes 0 No 9 Don't know Text box	

MEDICATION

We are interested in medications you are currently taking or have taken in the past 12 months (select all that apply):

Medication Type	Have you taken these in the past 12 months?	[IF YES] How often?
ACE-inhibitors to lower blood pressure (e.g. benazepril, captopril, enalapril, lisinopril, ramipril)	1 Yes 0 No 9 Don't know	1 Currently taking each day 2 Taken within the last few months (during the COVID-19 pandemic) but not every day 3 Taken before Jan 2020 but not currently 9 Don't know
Angiotension II Receptor Blockers to lower blood pressure (e.g. candesartan, losartan, telmisartan, valsartan)	1 Yes 0 No 9 Don't know	1 Currently taking each day 2 Taken within the last few months (during the COVID-19 pandemic) but not every day 3 Taken before Jan 2020 but not currently 9 Don't know

Medication Type	Have you taken these in the past 12 months?	[IF YES] How often?
Antibiotics	1 Yes 0 No 9 Don't know	1 Currently taking each day 2 Taken within the last few months (during the COVID-19 pandemic) but not every day 3 Taken before Jan 2020 but not currently 9 Don't know
Antivirals (e.g. lopinavir-ritonavir, remdesivir)	1 Yes 0 No 9 Don't know	1 Currently taking each day 2 Taken within the last few months (during the COVID-19 pandemic) but not every day 3 Taken before Jan 2020 but not currently 9 Don't know
Allergy medications	1 Yes 0 No 9 Don't know	1 Currently taking each day 2 Taken within the last few months (during the COVID-19 pandemic) but not every day 3 Taken before Jan 2020 but not currently 9 Don't know
Androgen deprivation therapy	1 Yes 0 No 9 Don't know	1 Currently taking each day 2 Taken within the last few months (during the COVID-19 pandemic) but not every day 3 Taken before Jan 2020 but not currently 9 Don't know
Asthma medications	1 Yes 0 No 9 Don't know	1 Currently taking each day 2 Taken within the last few months (during the COVID-19 pandemic) but

Medication Type	Have you taken these in the past 12 months?	[IF YES] How often?
		not every day 3 Taken before Jan 2020 but not currently 9 Don't know
Immunosuppressive or immunomodulatory medication (e.g. corticosteroids; disease-modifying anti-rheumetic drugs such as adalimumab, azathioprine, ciclosporin, etanercept, infliximab, methotrexate, rituximab, sulfasalazine, tocilizumab; anti-cytokine antibodies; interferons)	1 Yes 0 No 9 Don't know	1 Currently taking each day 2 Taken within the last few months (during the COVID-19 pandemic) but not every day 3 Taken before Jan 2020 but not currently 9 Don't know
Immunosuppressive medication associated with an organ transplant	1 Yes 0 No 9 Don't know	1 Currently taking each day 2 Taken within the last few months (during the COVID-19 pandemic) but not every day 3 Taken before Jan 2020 but not currently 9 Don't know
Blood thinners (e.g. apixaban, rivaroxaban, dabigatran)	1 Yes 0 No 9 Don't know	1 Currently taking each day 2 Taken within the last few months (during the COVID-19 pandemic) but not every day 3 Taken before Jan 2020 but not currently 9 Don't know
Non-steroidal anti-inflammatory drugs (e.g. ibuprofen such as Advil or Motrin; naproxen such as Aleve)	1 Yes 0 No 9 Don't know	1 Currently taking each day 2 Taken within the last few months (during the COVID-19 pandemic) but not every day 3 Taken before Jan 2020 but not currently 9 Don't know
Other pain/fever relievers (e.g. aspirin,	1 Yes	1 Currently taking each

Medication Type	Have you taken these in the past 12 months?	[IF YES] How often?
paracetamol or acetaminophen)	0 No 9 Don't know	day 2 Taken within the last few months (during the COVID-19 pandemic) but not every day 3 Taken before Jan 2020 but not currently 9 Don't know

PSYCHOSOCIAL IMPACT

Over the last 2 weeks, how often have you been bothered by the following problems?

	0 Not at all	1 Several Days	2 More than half of the days	3 Nearly every day
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it's hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

[IF YES TO ANY ABOVE] If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

0 Not difficult at all
1 Somewhat difficult
2 Very difficult
3 Extremely difficult

Over the last 2 weeks, how often have you been bothered by the following problems?

	0 Not at all	1 Several Days	2 More than half of the days	3 Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				

[IF YES TO ANY ABOVE] If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

0 Not difficult at all
1 Somewhat difficult
2 Very difficult
3 Extremely difficult

We would like you to compare your physical and emotional health before the pandemic compared to now during the pandemic.

	Excellent	Very Good	Good	Fair	Poor
In general, would you say your current mental/emotional health is:	○	○	○	○	○

	Better	About the Same	Worse
Your current mental/emotional health now compared to before the pandemic is:	○	○	○

Stressful situations have the potential to affect the relationships around you. We understand that many things may have changed in your life due to the impact of the pandemic. In the next set of questions, we are interested in how your relationships have changed since the pandemic.

My relationship with:	has become closer than before the pandemic	is about the same as before the pandemic	is more distant or strained than before the pandemic
Intimate partner ○ N/A (I do not have a partner)	○	○	○
Other family members (excluding intimate partner)	○	○	○
Friends	○	○	○
Neighbours	○	○	○
People you don't know but are in your community	○	○	○

Have you accessed mental health services during the COVID-19 pandemic?
0 No
1 Yes - using resources that I already had in place
2 Yes – I have initiated new use of services
8 Prefer not to answer
9 Don't know

[IF YES – 1,2] Have you accessed mental health services during the COVID-19 pandemic for any of the following conditions? (check all that apply)
1 Anxiety
2 Depression
3 Stress
8 Prefer not to answer
9 Don't know

Has anyone in your household accessed mental health services during the COVID-19 pandemic?
0 No
1 Yes - using resources that they already had in place
2 Yes – they have initiated new use of services
8 Prefer not to say
9 Don't know

SOCIOECONOMIC IMPACT

Prior to the declaration of public health emergency in your province what was your employment status?
1 Full-time employed / self-employed
2 Part-time employed / self-employed
3 Retired
4 Looking after home and/or family
5 Unable to work because of sickness or disability
6 Unemployed
7 Doing unpaid or voluntary work
8 Student
88 Prefer not to answer

[IF YES to 1,2] Has your employment changed because of the pandemic?
0 No
1 Yes

[IF YES] check all that apply
1 Nature of work has changed
2 External workplace has changed
3 Work from home
4 Reduced wages/ hours
5 Loss of employment
8 Prefer not to answer

[If YES to 3, 4, 5, 6, 7, 8] Has your employment changed because of the pandemic?
0 No
1 Yes – redeployed into healthcare for pandemic response
2 Yes – redeployed into other essential services for pandemic response
3 Other _____
8 Prefer not to answer

What is the highest level of education you have completed?
1 Elementary School
2 High School
3 Trade, technical or vocation school, apprenticeship training or technical CEGEP
4 Diploma from a community college, pre-university CEGEP or non-university certificate
5 University certificate (below Bachelor's level)
6 Bachelor's degree
7 Graduate degree (MSc, MBA, MD, PhD, etc.)
0 None
8 Prefer not to answer

Are you currently enrolled in an education/training program?

0 No
1 Yes

[IF YES] Has your education been disrupted because of the pandemic?
0 No change
1 Learning from home
2 Suspended/ cancelled learning
3 Yes – redeployed into healthcare or essential services for pandemic response
4 Other - _____
8 Prefer not to answer
9 Don't know

Prior to the pandemic, what was your approximate total household income (from all sources) before taxes last year? Please include the total income including salaries, pensions and allowances.
1 Less than $10,000
2 $10,000 - $24,999
3 $25,000 - $49,999
4 $50,000 - $74,999
5 $75,000 - $99,999
6 $100,000 - $149,999
7 $150,000 - $199,999
8 $200,000 or more
88 Prefer not to answer
99 Don't know

Has your monthly household income been changed because of the COVID-19 pandemic?
1 Substantially decreased
2 Somewhat decreased
3 No change
4 Somewhat increased
5 Substantially increased

Have your household savings been changed because of the COVID-19 pandemic?
1 Substantially decreased
2 Somewhat decreased
3 No change
4 Somewhat increased
5 Substantially increased

Have changes in you/your family's financial situation during the COVID-19 pandemic made it hard for you to pay for the basics like food, housing, medical care and heating?
1 Not hard at all
2 Somewhat hard

3 Very hard

Since the declaration of a public health emergency for COVID-19 in your province, has anyone in your household ever received food from a food bank, soup kitchen or other charitable agency?
1 Yes
0 No
8 Prefer not to answer
9 Don't know

[IF YES] How many times? _____

On a scale of 1 to 7, please indicate how much you worry about having enough money to do what is important for you/your family:
Rarely/never (1) --- Always (7)

On a scale of 1 to 7, please indicate if you have the financial resources you need to meet you/your family's needs:
Rarely/never (1) --- Always (7)

We'd like to ask you about giving and receiving support during the pandemic.
Have you <u>provided</u> help, aid or support to others (friends, family, neighbours, community/volunteer organization, employer) because of the pandemic?
1 Yes
0 No
9 Don't know

[IF YES] what kind of help, aid or support did you provide and to whom? (check all that apply)

	Emotional/ psychological	Financial	Medical	Information	Practical support (e.g. housing, childcare, clean-up, food delivery)	Material goods/donations (e.g. furniture, clothing)
Family (spouse, parent, other relatives)						
Friend(s)/ Neighbour(s)						
Community /volunteer organization						
Employer						

Have you looked for help, aid or support (including from friends, family, community or government) because of the pandemic?

1 Yes
0 No
9 Don't know

Have you received help, aid or support (including from friends, family, community or government) because of the pandemic?

1 Yes
0 No
9 Don't know

[IF YES] what kind of help, aid or support did you receive and from whom? (check all that apply)

	Emotional/ psychological	Financial	Medical	Information	Practical support (e.g. housing, childcare, clean-up, food delivery)	Material goods/donations (e.g. furniture, clothing)
Family (spouse, parent, other relatives)						
Friend(s)/ Neighbour(s)						
Community/ volunteer organization						
Employer						
Professional (doctor, lawyer, teacher, counsellor, spiritual leader, financial advisor)						
General media (TV, internet, social media)						
Provincial or Federal Health authorities (e.g. help/information phone lines, websites, social media)						
Government (financial support, financial relief, resources)						

ANTHROPOMETRICS

Height (cm)
value (in cm or feet and inches)
8 Prefer not to answer
9 Don't know

Weight (Kg)
Measurement _____pounds OR _____kilograms
8 Prefer not to answer
9 Don't know