

Modified COVID-19 Yorkshire Rehabilitation Scale (C19-YRSm)

Self-report version

Patient name:

Hospital number:

Date:

Time:

The purpose of this questionnaire is to find out more about your current problems following COVID-19 illness. Your responses will be recorded in your clinical notes. We will use this information to monitor your symptoms, offer treatments and assess your response to treatment.

This questionnaire will take around 10 minutes. If there are any topics you don't want to talk about you can choose not to respond.

Do you consent for this information to be used for audit and research as well? Yes No

SYMPTOM SEVERITY

*Please answer the questions below to the best of your knowledge.
 'Now' refers to how you feel now/this week (last 7 days).
 "Pre-COVID" refers to how you were feeling prior to contracting the illness.
 If you are unable to recall this, just state 'don't know'*

Rate the severity of each problem on a scale of 0-3:

0 = None; no problem

1 = Mild problem; does not affect daily life

2 = Moderate problem; affects daily life to a certain extent

3 = Severe problem; affects all aspects of daily life; life-disturbing

1. Breathlessness	Breathlessness:	Now	Pre-COVID
	a) At rest	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	b) Changing position e.g. from lying to sitting or sitting to lying	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	c) On dressing yourself	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	d) On walking up a flight of stairs	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
2. Cough/ throat sensitivity/ voice change	Cough/ throat sensitivity	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	Change of voice	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>

3. Fatigue (tiredness not improved by rest)	Fatigue levels in your usual activities	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
4. Smell/taste	Altered smell	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	Altered taste	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
5. Pain/discomfort	Chest pain	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	Joint pain	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	Muscle pain	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	Headache	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	Abdominal pain	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
6. Cognition	Problems with concentration	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	Problems with memory	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	Problems with planning	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
7. Palpitations/dizziness	Palpitations in certain positions, activity or at rest	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	Dizziness in certain positions, activity or at rest	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
8. Post-exertional malaise (worsening of symptoms)	Crashing or relapse hours or days after physical, cognitive or emotional exertion	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
9. Anxiety/ mood	Feeling anxious	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	Feeling depressed	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	Having unwanted memories of your illness or time in hospital	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	Having unpleasant dreams about your illness or time in hospital	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	Trying to avoid thoughts or feelings about your illness or time in hospital	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
10. Sleep	Sleep problems, such as difficulty falling asleep, staying asleep or oversleeping	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>

FUNCTIONAL ABILITY

11. Communication	Difficulty with communication/word finding difficulty/understanding others	Now	Pre-COVID
		0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
12. Walking or moving around	Difficulties with walking or moving around	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
13. Personal care	Difficulties with personal tasks such as using the toilet or getting washed and dressed	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
14. Other activities of Daily Living	Difficulty doing wider activities, such as household work, leisure/sporting activities, paid/unpaid work, study or shopping	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
15. Social role	Problems with socialising/interacting with friends* or caring for dependants	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
	*related to your illness and not due to social distancing/lockdown measures		

OTHER SYMPTOMS

Please select any of the following symptoms you have experienced since your illness in the last 7 days. Please also select any previous problems that have worsened for you following your illness.

- Fever
- Skin rash/ discolouration of skin
- New allergy such as medication, food etc
- Hair loss
- Skin sensation (numbness/tingling/itching/nerve pain)
- Dry eyes/ redness of eyes
- Swelling of feet/ swelling of hands
- Easy bruising/ bleeding
- Visual changes
- Difficulty swallowing solids
- Difficulty swallowing liquids
- Balance problems or falls
- Weakness or movement problems or coordination problems in limbs
- Tinnitus
- Nausea
- Dry mouth/mouth ulcers
- Acid Reflux/heartburn
- Change in appetite
- Unintentional weight loss
- Unintentional weight gain
- Bladder frequency,urgency or incontinence

- Constipation, diarrhoea or bowel incontinence
- Change in menstrual cycles or flow
- Waking up at night gasping for air (also called sleep apnea)
- Thoughts about harming yourself

Other symptoms – free text

OVERALL HEALTH

How good or bad is your health overall in the last 7 days?

For this question, a score of 10 means the BEST health you can imagine. 0 means the WORST health you can imagine.

a) Now: WORST HEALTH 0 1 2 3 4 5 6 7 8 9 10 BEST HEALTH

b) Pre-Covid: WORST HEALTH 0 1 2 3 4 5 6 7 8 9 10 BEST HEALTH

EMPLOYMENT

Occupation: _____

Has your COVID-19 illness affected your work?

- No change
- On reduced working hours
- On sickness leave
- Changes made to role/ working arrangements (such as working from home or lighter duties)
- Had to retire/ change job
- Lost job

Any other comments/concerns: _____

PARTNER/FAMILY/CARER PERSPECTIVE

This is space for your partner, family or carer to add anything from their perspective: