Appendix SI. COVID-19 Rehabilitation Needs Questionnaire (RehabNeQ)

Time of Infection

1) When did you test positive for the SARS-COV-2 virus?

- O < 1 month
- O ≥ 1 month
- O ≥ 2 months
- O ≥ 3 months
- O Please indicate the exact date of the test result, if known

_____

Health Problems caused by SARS-CoV-2

2) The health problems listed below are limitations that you have noticed due to your infection. Please indicate how problematic they were for you. If you have had any health problems, please state whether you have been treated for them and whether they persist.

	no problem ⟷ extreme problem					Do/did you receive treatment for it?	Do the problems still exist?
Sleep problems This includes problems falling asleep, sleeping through the night and waking up early	O	O	O	O	O	O Yes O No	O Yes O No
Bowel dysfunction e.g. diarrhea, and constipation.	O	O	O	O	O	O Yes O No	O Yes O No
Bladder dysfunction e.g. incontinence, bladder or kidney stones, kidney problems, urine leakage and urine back up	O	O	O	O	O	O Yes O No	O Yes O No
Restrictions on movement Limitation in range of motion of a joint	O	O	O	O	O	O Yes O No	O Yes O No
Muscular problems uncontrolled, jerky muscle movements, such as uncontrolled muscle twitches or spasms	O	O	O	O	O	O Yes O No	O Yes O No
Respiratory problems difficulty in breathing and increased secretions	O	O	O	O	O	O Yes O No	O Yes O No
Limitations of the sense of smell e.g. reduced or altered olfactory perception	O	O	O	O	O	O Yes O No	O Yes O No
Limitations of the sense of taste e.g. reduced or altered taste perception	O	O	O	O	O	O Yes O No	O Yes O No
Circulatory problems or circulatory disorders involves swelling of veins, feet, arms, legs	O	O	O	O	O	O Yes O No	O Yes O No
Lassitude e.g. increased fatigue	O	O	O	O	O	O Yes O No	O Yes O No
Fears, anxiety	O	O	O	O	O	O Yes O No	O Yes O No
Pain in your day-to-day life If so, where?	O	O	O	O	O	O Yes O No	O Yes O No

- ○ Neck/shoulder
- ○ Thoracic spine
- ○ Lumbarspine
- ○ Arms and legs
- ○ other ……

3) Please name up to five additional health problems that have arisen due to COVID-19 disease.

✎ ……

✎ ……

✎ ……

✎ ……

✎ ……

Therapy

4) Have you been hospitalized for SARS-CoV-2 infection?

- ○ No
- ○ Yes

If so, have you been ventilated?

- ○ No
- ○ Yes

If so, how long?

- ○ 1-3 days
- ○ 3-7 days
- ○ 1-2 weeks
- ○ 2-4 weeks
- ○ > 4 weeks

5) Have you received treatment for the infection and health problems? Check all that apply

	No	Yes	If so, how long or how often?
O Inpatient rehabilitation following hospitalization	O	O	
O Full-time outpatient rehabilitation	O	O	
O Outpatient therapy (e.g. physiotherapy)	O	O	
O technical aids	O	O	

6) Did you have difficulties in obtaining the necessary therapeutic measures or aids from yourself?

O Yes
O No

7) It would have been important for me to receive the following therapy options:
Check all that apply

O Inpatient rehabilitation following hospitalisation
O Full-time outpatient rehabilitation
O outpatient therapy (e.g. physiotherapy)
O appointment at a special aftercare center for Covid-19 patients
O Offer to talk/ contact person
O I have received everything I needed.

8)	very satisfied	statisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
Overall, I am satisfied with the received Therapy options	O	O	O	O	O

Activity and participation

9) The following section is about problems you experience in your everyday life. Please consider the time since your infection, including both the good and bad days. Please indicate whether the problems still exist today.

How much of a problem …	**no problem** ←				**extreme problem** →	**Do the problems still exist today?**	
… do you have carrying out daily routine?	O	O	O	O	O	O Yes	O No
… is handling stress for you?	O	O	O	O	O	O Yes	O No
… is doing things that require the use of your hands and fingers, such as picking up small objects or opening a container?	O	O	O	O	O	O Yes	O No
… is getting where you want to go?	O	O	O	O	O	O Yes	O No

… is using public transportation?	O	O	O	O	O	O Yes	O No
… is using private transportation??	O	O	O	O	O	O Yes	O No
… is looking after your health, eating well, exercising or taking your medicine?	O	O	O	O	O	O Yes	O No
… do you have with getting your household tasks done?	O	O	O	O	O	O Yes	O No
… do you have providing care or support for others?	O	O	O	O	O	O Yes	O No
… do you have interacting with people?	O	O	O	O	O	O Yes	O No
… do you have with intimate relationships?	O	O	O	O	O	O Yes	O No
… do you have with doing things for relaxation or pleasure?	O	O	O	O	O	O Yes	O No
… do you have with shortness of breath during physical exertion?	O	O	O	O	O	O Yes	O No

Quality of life and general health

10) The next questions are about how you rate your quality of life in general and in other areas of your life. Please think about your life in the last 30 days. Please keep in mind your standards, hopes, pleasures and concerns.

	very good	good	Neither poor nor good	poor	very poor
How would you rate your quality of life?	O	O	O	O	O

	very satisfied	satisfied	Neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
How satisfied are you with your health?	O	O	O	O	O
How satisfied are you with your ability to perform your daily living activities??	O	O	O	O	O
How satisfied are you with yourself?	O	O	O	O	O
How satisfied are you with your personal relationships?	O	O	O	O	O
How satisfied are you with your living conditions?	O	O	O	O	O

Health Care Services

11) The following questions relate to your visits to health care professionals due to the infection: Who did you visit or who visited you in your home? Check all that apply

- ○ General practitioner / family doctor
- ○ Specialist for physical and rehabilitative medicine
- ○ Other specialist (e.g. internist, cardiologist, pulmonologist)
- ○ Physiotherapist
- ○ Psychologist
- ○ Alternative therapies (alternative practitioner, acupuncturist, osteopath, chiropractor)
- ○ Pharmacist or chemist
- ○ Home health care worker
- ○ Statutory health insurance on-call service
- ○ Special practice for Covid-19 patients
- ○ Staff of the public health department
- ○ Others, please specify: ……
- ○ During and since the infection I have had no contact with any health care professional.
  Continue with question 13

12) How satisfied were you with your treatment with this professional group with regard to your health problem in the context of the infection?
(every professional group stated on question 11)

	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
General practitioner / family doctor	○	○	○	○	○
Specialist for physical and rehabilitative medicine	○	○	○	○	○
Other specialist (e.g. internist, cardiologist, pulmonologist)	○	○	○	○	○
Physiotherapist	○	○	○	○	○
Psychologist	○	○	○	○	○
Alternative therapies (alternative practitioner, acupuncturist, osteopath, chiropractor)	○	○	○	○	○
Pharmacist or chemist	○	○	○	○	○
Home health care worker	○	○	○	○	○
Statutory health insurance on-call service	○	○	○	○	○
Special practice for Covid-19 patients	○	○	○	○	○
Staff of the public health department	○	○	○	○	○
Others, please specify: ✎……	○	○	○	○	○

13) Did or had you wish for medical or medical/therapeutic treatment in connection with the infection with SARS-CoV-2, but did NOT receive it?

- ○ No → **continue with question 14**
- ○ For what reasons did you not get the treatment you needed? *(Check all that apply)*

  - ○ I was rejected because of my Covid-19 disease.
  - ○ The protective equipment of the doctor/therapist was insufficient.
  - ○ I did not know who to turn to.
  - ○ There was no treatment option.
  - ○ I was told that the doctor did not have enough budget for therapy.
  - ○ I thought that I was not sick enough.
  - ○ Other reasons, please specify:

    ✎……..

14)

	very satisfied	statisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
How satisfied are you with the range of health services in your district during the weeks of the Corona pandemic?	○	○	○	○	○

Personal Information

15) Please indicate your sex:

- ○ female
- ○ male

16) Your age

✎……Years

17) Your size

✎……cm

18) Your weight

✎……kg

19) What is your current marital status?

- ○ Single
- ○ Married
- ○ Cohabiting or in a partnership
- ○ Separated or divorced
- ○ Widowed

20) Who do you live with in a household? Who else lives in your household besides you? (Check all that apply)

- ○ Nobody, I live alone
- ○ Children under 14 years, Number of children _____
- ○ young people between 14 and 17 years, Number _____
- ○ persons between 18 and 64 years, number of persons_____
- ○ persons over 64 years of age, number of persons_____
- ○ I live in an institution (e.g. retirement home, nursing home).
- ○ I live in a shared flat

21) Which vocational training qualification / which educational level do you have? (Check all that apply)

- ○ No vocational qualification and not in vocational training
- ○ Still in training (vocational preparation year, apprentice, trainee, pupil, student)
- ○ Completion of a vocational training course (apprenticeship)
- ○ Completion of a vocational school education (vocational school, commercial school, preparatory service for the middle service in public administration)
- ○ Completed at a technical college, master craftsman's college, technical college, vocational college or technical academy
- ○ Bachelor's degree at (technical) university
- ○ Diploma, Master's, Magister or State Examination completed at (technical) college or university
- ○ Doctorate, Habilitation

22) Are you currently in paid employment?

- ○ Yes
  - ○ However, I am currently unfit for work.
- ○ No,
  - ○ ... I am looking for work.
  - ○ ... I am retired.

23) What district are you from? (specific in Germany)

✎……

Thank you for your participation!