EPINET
Early Psychosis Intervention Network

Client ID # _____ Date of Administration: _____

COVID-19 SUPPLEMENT

CLIENT SELF-ADMINISTERED OR CLINICIAN-ADMINISTERED

1. **Since the last assessment, have you had COVID-19 related symptoms like a cough, fever, shortness of breath or difficulty breathing?**
   - ○ Yes
   - ○ No

2. **Since the last assessment, have you been tested for the coronavirus?**
   - ○ Yes
   - ○ No → ***Skip to Q4***

3. **What was the result?**
   Select one.
   - ○ I have been tested and I tested positive (I had/have coronavirus)
   - ○ I have been tested and I tested negative (I did not have coronavirus)
   - ○ I have been tested and I do not know the result

4. **Since the last assessment, have you received a coronavirus vaccine?**
   - ○ Yes, I have received one or both vaccine shots
   - ○ No