## Appendix A - Primary Outcome Measure: Online Symptom and Activity Survey

Information

1 What is your name? \*

Please write your answer here:

2 How old are you?

Please choose **only one** of the following:

* 13-18
* 8-12
* 5-7

Symptoms Before Activity

3 Select the number to describe your symptoms. How much of a problem is it?

**Only answer this question if the following conditions are met: Age 13-18 (PCSI-SR13)**

Please choose the appropriate response for each item:

|   | 0 - Not a problem | 1 | 2 | 3 - moderate problem | 4 | 5 | 6 - Severe problem |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Headache | □ | □ | □ | □ | □ | □ | □ |
| Nausea | □ | □ | □ | □ | □ | □ | □ |
| Balance Problems | □ | □ | □ | □ | □ | □ | □ |
| Dizziness | □ | □ | □ | □ | □ | □ | □ |
| Fatigue | □ | □ | □ | □ | □ | □ | □ |
| Sadness | □ | □ | □ | □ | □ | □ | □ |
| Nervous/Anxious | □ | □ | □ | □ | □ | □ | □ |

4 Select the number to describe your symptoms. How much of a problem is it?

**Only answer this question if the following conditions are met: Age 8-12 (PCSI-SR8)**

Please choose the appropriate response for each item:

|   | 0 - Not a problem | 1 - a little  | 2 - a lot |
| --- | --- | --- | --- |
| Does your head hurt? | □ | □ | □ |
| Do you feel sick to your stomach? | □ | □ | □ |
| Do you have any balance problems like you might fall when you walk, run or stand? | □ | □ | □ |
| Do you feel dizzy? (like things around you are spinning or moving) | □ | □ | □ |
| Do you feel more tired than usual? | □ | □ | □ |
| Do you feel sad? | □ | □ | □ |
| Do you feel nervous or worried? | □ | □ | □ |

5 Select the number to describe your symptoms. How much of a problem is it?

**Only answer this question if the following conditions are met: Age 5-7 (PCSI-SR5)**

Please choose the appropriate response for each item:

|   | 0 = Not a problem | 1 = A little  | 2 = A lot |
| --- | --- | --- | --- |
| Does your head hurt? | □ | □ | □ |
| Do you feel sick to your stomach like you are going to throw up? | □ | □ | □ |
| Do you feel like you might fall when you walk, run or stand? | □ | □ | □ |
| Do you feel dizzy? (like things are spinning or moving) | □ | □ | □ |
| Do you feel more tired than usual? | □ | □ | □ |
| Do you feel sad? | □ | □ | □ |
| Do you feel nervous or worried? | □ | □ | □ |

Exercise

6 Did you do your exercise home program today? \*

Please choose **only one** of the following:

* Yes
* No

Activity Details

7 What did you choose as your activity? (eg. bike, walk, elliptical)

**Only answer this question if the following conditions are met: Exercise - yes**

Please write your answer here:

8 How long did you exercise for? (in minutes)

**Only answer this question if the following conditions are met: Exercise - yes**

Please write your answer here:

*

9 How hard was the activity you just completed?

 **Only answer this question if the following conditions are met: Exercise - yes**

Please choose **only one** of the following:

* 1 - very, very easy
* 2 - very easy
* 3 - easy
* 4 - just feeling a strain
* 5 - starting to get hard
* 6 - getting quite hard
* 7 - hard
* 8 - very hard
* 9 - very, very hard
* 10 so hard I'm going to stop

Symptoms After Activity

10 Select the number to describe your symptoms. How much of a problem is it?

**Only answer this question if the following conditions are met: Age 13-18 and Exercise - yes**

Please choose the appropriate response for each item:

|   | 0 - Not a problem | 1 | 2 | 3 - moderate problem | 4 | 5 | 6 - Severe problem |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Headache | □ | □ | □ | □ | □ | □ | □ |
| Nausea | □ | □ | □ | □ | □ | □ | □ |
| Balance Problems | □ | □ | □ | □ | □ | □ | □ |
| Dizziness | □ | □ | □ | □ | □ | □ | □ |
| Fatigue | □ | □ | □ | □ | □ | □ | □ |
| Sadness | □ | □ | □ | □ | □ | □ | □ |
| Nervous/Anxious | □ | □ | □ | □ | □ | □ | □ |

11 Select the number to describe your symptoms. How much of a problem is it?

**Only answer this question if the following conditions are met: Age 8-12 and Exercise - yes**

Please choose the appropriate response for each item:

|   | 0 - Not a problem | 1 - a little  | 2 - a lot |
| --- | --- | --- | --- |
| Does your head hurt | □ | □ | □ |
| Do you feel sick to your stomach | □ | □ | □ |
| Do you have any balance problems... | □ | □ | □ |
| Do you feel dizzy? | □ | □ | □ |
| Do you feel more tired than usual? | □ | □ | □ |
| Do you feel sad? | □ | □ | □ |
| Do you feel nervous or worried? | □ | □ | □ |

12 Select the number to describe your symptoms. How much of a problem is it?

**Only answer this question if the following conditions are met: Age 5-7 and Exercise - yes**

Please choose the appropriate response for each item:

|   | 0 - Not a problem | 1 - a little  | 2 - a lot |
| --- | --- | --- | --- |
| Does your head hurt? | □ | □ | □ |
| Do you feel sick to your stomach like you are going to throw up? | □ | □ | □ |
| Do you feel like you might fall when you walk, run or stand? | □ | □ | □ |
| Do you feel dizzy? (like things around you are spinning or moving) | □ | □ | □ |
| Do you feel more tired than usual? | □ | □ | □ |
| Do you feel sad? | □ | □ | □ |
| Do you feel nervous or worried? | □ | □ | □ |

Comments

13 If you have anything else to tell us please write it here: