



National Center for
PTSD
POSTTRAUMATIC STRESS DISORDER

COVID-19 Exposure Scale

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Reference: National Center for PTSD (NCPTSD)
COVID-19 Workgroup. (2021). COVID-19 Exposure
Scale. [Unpublished measure]. Available from
<https://www.ptsd.va.gov>.

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COVID-19 Exposure Scale

This survey asks questions about your experience with COVID-19 (the viral infection caused by the SARS-CoV-2 virus, also known as the novel coronavirus). These experiences may have happened to you, someone close to you who shares your home, or someone close to you who does not share your home (for example, a close friend, co-worker, family member who does not live with you, or child-care provider).

Section A. Questions 1-3 ask whether you, or anyone close to you has ever tested positive for COVID-19 (any kind of test – nose, cheek or throat swab, or blood test, including an antibody test for earlier infection)

1. I tested positive for COVID-19 **YES** **NO**
 2. Someone who lives in my home tested positive for COVID-19 **YES** **NO**
 3. Someone close to me (but not living in my home) tested positive for COVID-19 (for example, a friend, a family member who does not live with you, a co-worker, or child care provider.) **YES** **NO**
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Section B.

4. Did you ever have, or probably have, COVID-19 (even if you did not get tested)? **YES** **NO**

If you answered yes to question 4, complete questions 5-12.

If you answered no to question 4, skip to Section C.

5. I became sick with COVID-19, but symptoms were not severe **YES** **NO**
 6. My COVID-19 symptoms were severe enough that there were serious concerns about not surviving **YES** **NO**
 7. My COVID-19 symptoms required a visit to the Emergency Room **YES** **NO**
 8. My COVID-19 symptoms required an overnight stay at a hospital **YES** **NO**
 9. If you answered yes to question 8, how many days in the hospital? _____
 10. My COVID-19 symptoms required admission to the Intensive Care Unit (ICU) **YES** **NO**
 11. If you answered yes to question 10, how many days in ICU? _____
 12. My COVID-19 symptoms were severe enough to require intubation/mechanical ventilation (doctor puts a tube down your throat to help with breathing) **YES** **NO**
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Section C.

13. Did someone who lives in your house ever have, or probably have, COVID-19 (even if they did not get tested)? **YES** **NO**

If you answered yes to question 13, complete questions 14 to 23. If multiple people in your home had COVID-19 (even if they did not get tested) please answer all that apply.

If you answered no to question 13, skip to Section D.

14. They became sick with COVID-19, but symptoms were not severe **YES** **NO**
 15. Their COVID-19 symptoms were severe enough that there were serious concerns about not surviving **YES** **NO**
 16. Their COVID-19 symptoms required a visit to the Emergency Room **YES** **NO**
 17. Their COVID-19 symptoms required an overnight stay at a hospital **YES** **NO**
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18. If you answered yes to question 17, how many days in the hospital? _____
19. Their COVID-19 symptoms required admission to the Intensive Care Unit (ICU) **YES** **NO**
20. If you answered yes to question 19, how many days in ICU? _____
21. Their COVID-19 symptoms were severe enough to require intubation/mechanical ventilation (doctor puts a tube down your throat to help with breathing) **YES** **NO**
22. They died of COVID-19 **YES** **NO**
23. If you answered yes to question 22, please list their relationship to you (for example, child, sibling, spouse)
- _____
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Section D.

24. Did someone close to you who does not live in your home ever have, or probably have, COVID-19 (even if they did not get tested)? This might be a friend, a family member who does not live with you, a co-worker, or child care provider. **YES** **NO**

If you answered yes to question 24, complete questions 25 - 34. If multiple people close to you (not in your home) had COVID-19, check all that apply.

If you answered no to question 24, skip to Section E.

25. They became sick with COVID-19, but symptoms were not severe **YES** **NO**
26. Their COVID-19 symptoms were severe enough that there were serious concerns about not surviving **YES** **NO**
27. Their COVID-19 symptoms required a visit to the Emergency Room **YES** **NO**
28. Their COVID-19 symptoms required an overnight stay at a hospital **YES** **NO**
29. If you answered yes to question 28, how many days in the hospital? _____
30. Their COVID-19 symptoms required admission to the Intensive Care Unit (ICU) **YES** **NO**
31. If you answered yes to question 30, how many days in ICU? _____
32. Their COVID-19 symptoms were severe enough to require intubation/mechanical ventilation (doctor puts a tube down your throat to help with breathing) **YES** **NO**
33. They died of COVID-19 **YES** **NO**
34. If yes, please list their relationship to you (for example, colleague or friend)
- _____
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Section E. The following questions ask about your experiences with COVID-19 as part of your day to day life, for example, as part of your job.

35. To your knowledge, as part of your job, did you have direct contact with people who tested positive for, or very likely had, COVID-19?
- Yes, *with* adequate physical distance or personal protective equipment (PPE) **YES**
- Yes, *without* adequate physical distance or personal protective equipment (PPE) **YES**
- No, I did not have direct contact with people who tested positive for, or very likely had, COVID-19 **NO**
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36. To your knowledge, as part of your job, did you have direct contact with others who *may* have had COVID-19?
Yes, *with* adequate physical distance or personal protective equipment (PPE) **YES**
Yes, *without* adequate physical distance or personal protective equipment (PPE) **YES**
No, I did not have direct contact with others who may have had COVID-19 **NO**
37. As part of your job, did you make decisions that impacted the health and well-being of COVID-19 patients (e.g., decided to take someone off a ventilator, decided whether to admit a patient to the hospital)? **YES** **NO**
38. As part of your job, did you witness people die from COVID-19? **YES** **NO**
39. Outside of your job, to your knowledge, did you have direct contact with people who tested positive for, or very likely had, COVID-19?
Yes, *with* adequate physical distance or personal protective equipment (PPE) **YES**
Yes, *without* adequate physical distance or personal protective equipment (PPE) **YES**
No, I did not have direct contact with people who tested positive for, or very likely had, COVID-19 **NO**