Supplement 1: Alphabetized list of all questionnaires in the VeCosCO protocol

The Brief Illness Perceptions Questionnaire (B-IPQ) consists of 8 items scored on a 11-point scale with different response options per item. A total score (range 0-80) can be computed, but the validity of this score depends on the type of condition the item responses are based on [1, 2].

The Checklist Individual Strength (CIS) measures aspects of participants fatigue across four domains: fatigue severity, concentration, motivation and activity [3]. The subscale fatigue severity consists of 8 items on a 7-point scale (range 8 – 56). A validated cut-off of 35 or higher on this subscale denotes severe fatigue. The CIS is a reliable and valid instrument for the assessment of fatigue severity and is sensitive to change [4]. Concentration problems are assessed using the subscale concentration problems from the CIS. The subscale consists of 5 items, scored on a 7-point scale. A cut-off threshold of ≥18 defines the presence of notable concentration problems [4].

The Checklist for post-IC Cognitive Complaints (CLC-IC) is adapted from the Checklist of Cognition and Emotion (CLC-24)[5], and is used to identify cognitive problems after being hospitalized on the ICU. The CLC-IC consists of 10 items describing cognitive problems for which has to be indicated whether the problem is present or not. The total score (range 0-10) is the sum of the number of cognitive problems present.

The 16-item Cognitive and Behavioural Responses to Symptoms questionnaire (CBRSQ)[6], consists of 11 items assessing certain beliefs about symptoms with 0 (highly disagree) to 4 (highly agree) and 5 items assessing how often certain strategies are used to deal with the symptoms with 0 (never) to 4 (always). Three subscales are derived from the 16 items: fear avoidance (range 0-24), damage avoidance (range 0-20), and all-or-nothing behaviour (range 0-20). Higher scores indicate more avoidance/all-or-nothing behaviour.

The Cognitive Failure Questionnaire (CFQ) is a subjective cognitive functioning questionnaire consisting of 25 questions about the frequency of everyday cognitive failures [7]. Items are scored from 1 (very often) to 5 (never). The total score (range 0-100) is computed by reverse scoring the items. A cut-off threshold of ≥44 defines a heightened frequency of cognitive failures.

The orthostatic intolerance subscale of the Composite Autonomic Scoring Scale (CASS) consists of 9 items [8]. Five items assess the presence of orthostatic intolerance after different activities in the last year with response options 1 (present) and 0 (not present). For the activity of getting up after sitting/laying down, there is one additional item scored from 1 (rarely) to 4 (always) assessing the frequency, and 1 additional item scored from 1 (mild) to 3 (severe) assessing the severity of the orthostatic tolerance. There is one item assessing the frequency of fainting following getting up after sitting/lying down in the last year which is scored from 0 (never) to 5 (five or more times). A total score over these items is computed (range 0-40) with higher scores indicating more severe orthostatic intolerance.

The DePaul Symptom Questionnaire Short form (DSQ-SF) consists of 14 items scored on a 5-point scale (range 0-4) assessing the frequency and severity of these common symptoms [9].

The Fatigue and Energy Scale (FES) is used to assess post-exertional exacerbation of fatigue [10]. The FES consists of 6 items investigating the presence of three physical and three mental symptoms at the given moment. Items are scored 0 (not present) to 10 (maximal present). The total score is the sum of the items (range 0-60) with higher scores indicating more post-exertional exacerbation.

The Fatigue Severity Scale (FSS) is a self-administered questionnaire with 9 items investigating the severity of fatigue in different situations during the past week [11]. Items are rated from 1 (strong
disagreement) to 7 (strong agreement). The total score represents the mean value of the 9 items [12].

The **Hospital Anxiety and Depression Scale** (HADS) consists of 7 items scored on a 4-point scale with different response options per item. The sum of these items is the total score (range 0-21) with cut-off threshold \( \geq 8 \) indicating the possibility of a depressive disorder [13].

The **Insomnia Severity Index** (ISI) consists of 7 items scored on a 5-point scale with different response options per item. The total score is computed by summing the item scores (range 0-28) with higher scores indicating lower sleep quality [14].

The **Jacobson-Fatigue Catastrophizing Scale** (J-FCS) consists of 10 items that describe a catastrophizing behaviour which are scored on a 5-point scale with 1 (never) to 5 (always). The total score is the average over the 10 items with a higher score indicating more catastrophizing behaviour [15].

The **Patient Health Questionnaire** (PHQ-9) consists of 9 items describing depressive symptoms which are scored from 0 (never) to 3 (almost every day). The total score is the sum of the 9 items (range 0-27) with cut-off threshold \( \geq 10 \) indicating the possibility of a moderate to severe depressive disorder [16].

The **Pittsburgh sleep questionnaire** consists of 19 items with different response options per item. Seven component scores can be computed from the 19 items. The weighted average of these seven components makes up the total score (range 0-21) with again higher scores indicating lower sleep quality [17].

The **Research and Development-36** (RAND-36) consists of the same 36 items as the Short Form Health Survey 36 but differs in the way the subscale scores are computed [18].

The **Self-Efficacy Scale 28** (SES28) consists of 7 items each scored on a 4-point scale with different response options per item with higher scores indicating more self-efficacy [19].

The **Short Form Health Survey 36** (SF-36) consists of 36 items scored on different response scales measuring 8 different health constructs. This results in 8 subscale scores, each with range (0-100) in which higher scores indicate better health outcomes [20].

The **Treatment Inventory of Costs in Patients with psychiatric disorders** (TIC-P) [21]. An adapted version of the TIC-P will be used which was developed in previous research on persistent symptoms after Lyme Borreliosis [22]. This adapted version consists of 13 items of which 8 items are assessing the presence of different physical and psychological complaints/disorders, 2 items assessing the use and nature of healthcare services, and 3 items assessing work situation.
Neuropsychological tests

The Controlled Oral Word Association Test is used to measure verbal fluency [23].

The D2 test, a visual cancellation test, will be used to measure sustained attention and concentration accuracy [24].

Digit-span forward is used to measure immediate verbal short-term memory [25].

Digit Span backwards measures working memory skills [25].

The Rey Auditory Verbal Learning test (immediate, delayed recall and recognition) is used to measure verbal memory.

The Rey Complex Figure test recall condition measures visual memory. The copy condition measures visuoconstruction [26, 27].

The Stroop 1 and 2 measure work speed by reading words and colors [28]. The Stroop Color-Word Test is used to measure cognitive interference [28].

The Trail Making Test A is used to measure visuo-spatial processing speed [29]. B is used to measure set switching and mental flexibility [29].

The Test of Memory Malingering is a visual learning test that is used to detect performance validity [30].

The animal fluency test assesses language skills [31].
References:


26. Rey A. L'examen psychologique dans les cas d'encéphalopathie traumatique. (Les problems.). Archives de psychologie. 1941.


