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v-safe
after vaccination
Health checker

English Sign Out


Home Health Check-ins My Profile


Hello, [REDACTED]



Have you received an additional dose of the COVID-19 vaccine?


Enter Vaccine Information

 View My Profile

 Add a Dependent

REGISTRANT CODE DATE OF BIRTH MOBILE NUMBER

Vaccines

 Vaccine: Janssen/Johnson & Johnson Dose 1 DATE REPORTED March 14 2021

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52°F Partly sunny 1:01 PM 5/7/2022

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













All set!

You have no pending Health Check-ins.

No Surveys found

Previous Activity

 Final Health Check-in	March 14 2022 2:31 pm
 6 Month Health Check-in	September 12 2021 4:49 pm
 3 Month Health Check-in	June 15 2021 5:58 pm
 42 day Health Check-in	April 25 2021 4:14 pm
 Weekly Health Check-in	April 18 2021 11:11 pm
 Weekly Health Check-in	April 11 2021 5:05 pm
 Weekly Health Check-in	April 5 2021 1:31 am
 Weekly Health Check-in	March 28 2021 3:04 pm
 Daily Health Check-in	March 21 2021 2:47 pm
 Daily Health Check-in	March 20 2021 3:54 pm
 Daily Health Check-in	March 19 2021 3:49 pm
 Daily Health Check-in	March 17 2021 4:22 pm
 Daily Health Check-in	March 16 2021 3:42 pm
 Daily Health Check-in	March 15 2021 3:54 pm
 Initial Health Check-in	March 14 2021 3:22 pm

Initial Health Check-in

Survey Name	Initial Health Check-in
Started	14 MAR 2021 22:15
Completed In	6:52 minutes

How are you feeling today?

- Good
- Fair
- Poor

Fever Check

Since your COVID-19 vaccination, have you had a fever or felt feverish?

- Yes
- No

Symptom Check

Have you had any of these symptoms today where you got the shot (injection site)?

- Pain
- Redness
- Swelling
- Itching
- None

Pain

- Mild
- Moderate
- Severe

Itching

- Mild
- Moderate
- Severe

Have you experienced any of these symptoms today?

- Chills
- Headache
- Joint pains
- Muscle or body aches
- Fatigue or tiredness
- Nausea
- Vomiting
- Diarrhea
- Abdominal pain
- Rash, not including the immediate area around the injection site
- None

Any other symptoms or health conditions you want to report? / About 5 minutes after injection, I got shooting pains down my arm through wrist and up over my shoulder through my neck. My wrist felt weak and limp. My throat and tongue started swelling about 20 minutes after injection. They gave me one 25 mg liquid cap of Diphenhydramine HCl. By 2 hours later, the swelling was entirely gone.

Muscle or body aches

- Mild
- Moderate
- Severe

Fatigue or tiredness

- Mild
- Moderate
- Severe

Health Impact

Did any of the symptoms or health conditions you reported today cause you to:

- Be unable to work or attend school
- Be unable to do your normal daily activities
- Get care from a doctor or other healthcare professional
- None of the above

Were you pregnant at the time of your COVID-19 vaccination?

- Yes
- No
- I don't know

What is your ethnic group?

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown or prefer not to say

What is your race?

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- White
- Other
- Unknown or prefer not to say

Daily Health Check-in

Survey Name	Daily Health Check-In
Started	16 MAR 2021 22:40
Completed in	1:52 minutes

How are you feeling today?

Good

Fair

Poor

Fever Check

Have you had a fever or felt feverish today?

Yes

No

Do you know your highest temperature reading from today?

Yes - in degrees Fahrenheit

Yes - in degrees Celsius

No - I don't remember the reading

No - I didn't take my temperature

Enter your highest temperature reading from today (degrees Fahrenheit). 102.1

Symptom Check

Have you had any of these symptoms today where you got the shot (injection site)?

Pain

Redness

Swelling

Itching

None

Pain

Mild

Moderate

Severe

Have you experienced any of these symptoms today?

Chills

Headache

Joint pains

Muscle or body aches

Fatigue or tiredness

Nausea

Vomiting

Diarrhea

Abdominal pain

Rash, not including the immediate area around the injection site

None

Any other symptoms or health conditions you want to report Jaw pain, ear pain, light sensitivity

Chills

Mild

Moderate

Severe

Headache

Mild

Moderate

Severe

Joint pains

Mild

Moderate

Severe

Muscle or body aches

Mild

Moderate

Severe

Fatigue or tiredness

Mild

Moderate

Severe

Abdominal pain

Mild

Moderate

Severe

Health Impact

Did any of the symptoms or health conditions you reported today cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other, please describe

Daily Health Check-in

Survey Name	Daily Health Check-In
Started	16 MAR 2021 22:50
Completed in	4:1 minutes

How are you feeling today?

Good

Fair

Poor

Fever Check

Have you had a fever or felt feverish today?

Yes

No

Do you know your highest temperature reading from today?

Yes - in degrees Fahrenheit

Yes - in degrees Celsius

No - I don't remember the reading

No - I didn't take my temperature

Enter your highest temperature reading from today (degrees Fahrenheit). 104.8

Symptom Check

Have you had any of these symptoms today where you got the shot (injection site)?

Pain

Redness

Swelling

Itching

None

Pain

Mild

Moderate

Severe

Have you experienced any of these symptoms today?

Chills

Headache

Joint pains

Muscle or body aches

Fatigue or tiredness

Nausea

Vomiting

Diarrhea

Abdominal pain

Rash, not including the immediate area around the injection site

None

Any other symptoms or health conditions you want to report Numbness in my fingers and tingling (left arm, ear aches, neck pain, dizziness

Chills

Mild

Moderate

Severe

Headache

Mild

Moderate

Severe

Joint pains

Mild

Moderate

Severe

Muscle or body aches

Mild

Moderate

Severe

Fatigue or tiredness

Mild

Moderate

Severe

Abdominal pain

Mild

Moderate

Severe

Health Impact

Did any of the symptoms or health conditions you reported today cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other, please describe

Daily Health Check-in

Survey Name	Daily Health Check-in
Started	19 MAR 2021 22:45
Completed In	3.28 minutes

How are you feeling today?

- Good
- Fair
- Poor

Fever Check

Have you had a fever or felt feverish today?

- Yes
- No

Do you know your highest temperature reading from today?

- Yes - In degrees Fahrenheit
- Yes - In degrees Celsius
- No - I don't remember the reading
- No - I didn't take my temperature

Enter your highest temperature reading from today (degrees Fahrenheit). 99.1

Symptom Check

Have you had any of these symptoms today where you got the shot (injection site)?

- Pain
- Redness
- Swelling
- Itching
- None

Pain

- Mild
- Moderate
- Severe

Itching

- Mild
- Moderate
- Severe

Have you experienced any of these symptoms today?

- Chills
- Headache
- Joint pains
- Muscle or body aches
- Fatigue or tiredness

- Nausea
- Vomiting
- Diarrhea
- Abdominal pain
- Rash, not including the immediate area around the injection site
- None

Any other symptoms or health conditions you want to report Jaw pain, light sensitivity, dizzy

Headache

- Mild
- Moderate
- Severe

Joint pains

- Mild
- Moderate
- Severe

Muscle or body aches

- Mild
- Moderate
- Severe

Fatigue or tiredness

- Mild
- Moderate
- Severe

Health Impact

Did any of the symptoms or health conditions you reported today cause you to:

- Be unable to work or attend school
- Be unable to do your normal daily activities
- Get care from a doctor or other healthcare professional
- None of the above

What type of healthcare visit did you have?

- Telehealth, virtual health, or email health consultation
- Outpatient clinic or urgent care clinic visit
- Emergency room or emergency department visit
- Hospitalization
- Other, please describe They said they may need to schedule a CT or MRI on Monday after an evaluation.

Daily Health Check-in

Survey Name	Daily Health Check-in
Started	17 MAR 2021 23:15
Completed In	7:52 minutes

How are you feeling today?

- Good
- Fair
- Poor

Fever Check

Have you had a fever or felt feverish today?

- Yes
- No

Do you know your highest temperature reading from today?

- Yes - In degrees Fahrenheit
- Yes - In degrees Celsius
- No - I don't remember the reading
- No - I didn't take my temperature

Enter your highest temperature reading from today (degrees Fahrenheit). 101.2

Symptom Check

Have you had any of these symptoms today where you got the shot (injection site)?

- Pain
- Redness
- Swelling
- Itching
- None

Pain

- Mild
- Moderate
- Severe

Itching

- Mild
- Moderate
- Severe

Have you experienced any of these symptoms today?

- Chills
- Headache
- Joint pains
- Muscle or body aches
- Fatigue or tiredness

- Nausea
- Vomiting
- Diarrhea

Abdominal pain

- Rash, not including the immediate area around the injection site
- None

Any other symptoms or health conditions you want to report I went to the doctor in person and he said I had brain swelling and toxic reaction, MTHFR double mutation C677T methylation process isn't normal with me, it's been more than 4 weeks. It matches the symptoms for toxic exposure for brain swelling including not remembering much since getting home from vaccination on March 14, abnormal hearth rhythm and rapid heartbeat, numbness and tingling in arm and fingers, flaccid limbs/wrist, impaired balance, dizziness, fever higher than 103 (went up to 104.5), difficulty thinking, reading and writing, neck stiffness, lethargy and non-responsive when family member tried to wake me up.

Headache

- Mild
- Moderate
- Severe

Joint pains

- Mild
- Moderate
- Severe

Muscle or body aches

- Mild
- Moderate
- Severe

Fatigue or tiredness

- Mild
- Moderate
- Severe

Abdominal pain

- Mild
- Moderate
- Severe

Health Impact

Did any of the symptoms or health conditions you reported today cause you to:

- Be unable to work or attend school
- Be unable to do your normal daily activities
- Get care from a doctor or other healthcare professional
- None of the above

What type of healthcare visit did you have?

- Telehealth, virtual health, or email health consultation
- Outpatient clinic or urgent care clinic visit
- Emergency room or emergency department visit
- Hospitalization
- Other, please describe

Daily Health Check-in

Survey Name	Daily Health Check-in
Started	21 MAR 2021 21:45
Completed in	2:12 minutes

How are you feeling today?

- Good
- Fair
- Poor

Fever Check

Have you had a fever or felt feverish today?

- Yes
- No

Do you know your highest temperature reading from today?

- Yes - in degrees Fahrenheit
- Yes - in degrees Celsius
- No - I don't remember the reading
- No - I didn't take my temperature

Enter your highest temperature reading from today (degrees Fahrenheit). 99.1

Symptom Check

Have you had any of these symptoms today where you got the shot (injection site)?

- Pain
- Redness
- Swelling
- Itching
- None

Pain

- Mild
- Moderate
- Severe

Itching

- Mild
- Moderate
- Severe

Have you experienced any of these symptoms today?

- Chills
- Headache
- Joint pains
- Muscle or body aches
- Fatigue or tiredness

- Nausea
- Vomiting
- Diarrhea
- Abdominal pain
- Rash, not including the immediate area around the injection site
- None
- Any other symptoms or health conditions you want to report Jaw pain, brain fog, lethargy.

Headache

- Mild
- Moderate
- Severe

Joint pains

- Mild
- Moderate
- Severe

Muscle or body aches

- Mild
- Moderate
- Severe

Fatigue or tiredness

- Mild
- Moderate
- Severe

Health Impact

Did any of the symptoms or health conditions you reported today cause you to:

- Be unable to work or attend school
- Be unable to do your normal daily activities
- Get care from a doctor or other healthcare professional

Daily Health Check-in

Survey Name	Daily Health Check-in
Started	20 MAR 2021 22:31
Completed in	3:17 minutes

How are you feeling today?

- Good
- Fair
- Poor

Fever Check

Have you had a fever or felt feverish today?

- Yes
- No

Do you know your highest temperature reading from today?

- Yes - in degrees Fahrenheit
- Yes - in degrees Celsius
- No - I don't remember the reading
- No - I didn't take my temperature

Enter your highest temperature reading from today (degrees Fahrenheit). 100.9

Symptom Check

Have you had any of these symptoms today where you got the shot (injection site)?

- Pain
- Redness
- Swelling
- Itching
- None

Pain

- Mild
- Moderate
- Severe

Itching

- Mild
- Moderate
- Severe

Have you experienced any of these symptoms today?

- Chills
- Headache
- Joint pains
- Muscle or body aches
- Fatigue or tiredness
- Nausea
- Vomiting
- Diarrhea
- Abdominal pain
- Rash, not including the immediate area around the injection site
- None
- Any other symptoms or health conditions you want to report Jaw pain severe enough it's hard to open my mouth to eat, dizziness, lethargy, legs buckle when trying to walk, neck pain and stiffness, brain fog.

Headache

- Mild
- Moderate
- Severe

Joint pains

- Mild
- Moderate
- Severe

Muscle or body aches

- Mild
- Moderate
- Severe

Fatigue or tiredness

- Mild
- Moderate
- Severe

Health Impact

Did any of the symptoms or health conditions you reported today cause you to:

- Be unable to work or attend school
- Be unable to do your normal daily activities
- Get care from a doctor or other healthcare professional
- None of the above

What type of healthcare visit did you have?

- Telehealth, virtual health, or email health consultation
- Outpatient clinic or urgent care clinic visit
- Emergency room or emergency department visit
- Hospitalization
- Other, please describe Telehealth with scheduled appointment on Monday -nurses keep asking if I've received a call from CDC based on severity and duration of fever and symptoms.

Weekly Health Check-in

Survey Name Weekly Health Check-in

Started 28 MAR 2021 22:01

Completed In 3.05 minutes

How are you feeling today?

Good

Fair

Poor

Since your last check-in, have you experienced any new or worsening symptoms or health conditions?

Yes

No

Please describe the symptoms or health conditions.

Chest pain through last night when inhaling, hypotension (90/52) and high resting heart rate (96).

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other - please describe

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes

No

Weekly Health Check-in

Survey Name Weekly Health Check-in

Started 05 APR 2021 08:23

Completed In 8.62 minutes

How are you feeling today?

Good

Fair

Poor

Since your last check-in, have you experienced any new or worsening symptoms or health conditions?

Yes

No

Please describe the symptoms or health conditions.

Nausea, vomiting, ER visit, + x2 urgent care & 4/4/21, 2 chest x-ray, EKG, referral to cardiologist & immunology, continued symptoms & 100 bpm resting hr & more chest pain. No underlying health conditions. MRI 4/14/21. Dr.no work thru 4/12. Help me!

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other - please describe

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes

No

Since your last COVID-19 vaccination, have you had a home or laboratory pregnancy test that was positive?

Yes

No

Weekly Health Check-in

Survey Name Weekly Health Check-in

Started 12 APR 2021 00:00

Completed In 2.68 minutes

How are you feeling today?

Good

Fair

Poor

Since your last check-in, have you experienced any new or worsening symptoms or health conditions?

Yes

No

Please describe the symptoms or health conditions.

Infectious disease expert is going to test for blood clots, send me for CTA scan, MRI is scheduled for April 14, Neurologist April 16.

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other - please describe

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes

No

Weekly Health Check-in

Survey Name Weekly Health Check-in

Started 19 APR 2021 06:03

Completed In 7.58 minutes

How are you feeling today?

Good

Fair

Poor

Since your last check-in, have you experienced any new or worsening symptoms or health conditions?

Yes

No

Please describe the symptoms or health conditions.

Aphasia, leg pain, continued back ache, severe headache, MRI and Venogram. Venous flow signal in left transverse and sigmoid sinus, small & irregular. Arachnoid granulation. 2013 MRI showed symmetry and all normal scan in contrast. Please help me!

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other - please describe

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes

No

42 day Health Check-in

Survey Name	42 day Health Check-in
Started	25 APR 2021 23:08
Completed In	6.32 minutes

How are you feeling today?

Good

Fair

Poor

Since your last check-in, have you experienced any new or worsening symptoms or health conditions?

Yes

No

Please describe the symptoms or health conditions.

Drops in blood pressure (85/52 & 100bpm resting her) Chest pain, racing heart, blurry vision, headache, dizziness, back pain, difficulty with speech, reading, writing walking, MD said symptoms like TIAs, and TBI, referral for neuro-rehab, physical th

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other - please describe PCP & Neurologists referrals declined by specialist as they say they don't have capacity to work with people with reaction after Covid-19 vaccination

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes

No

How would you describe your current state of health?

Excellent

Good

Fair

Poor

How is your health now compared to your health before your last COVID-19 vaccination?

Better

About the same

Worse

Do you believe your health problems might be related to your COVID-19 vaccination?

Yes

No

Since your last COVID-19 vaccination, have you had a home or laboratory pregnancy test that was positive?

Yes

No

3 Month Health Check-in

Survey Name	3 Month Health Check-in
Started	14 JUN 2021 00:30
Completed In	8.1 minutes

How are you feeling today?

Good

Fair

Poor

Since we last contacted you, have you experienced any new symptoms or health conditions?

Yes

No

Please describe the symptoms or health conditions.

Doubled over abdominal pain, blurry vision, cold sweat, leg pain Ringing in my ear, VOR dysfunction. Ongoing speech therapy, vestibular & physical therapy. All test: no underlying conditions. Next test: Transcranial Doppler (June 21).

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other - please describe Ongoing testing. Echocardiogram, Zio patch, EMG, hearing test, VNG, transcranial Doppler, EEG, allergist testing in July for polysorbate 80, still on full disability, not medically cleared to drive, not cleared to walk more than 25 minutes a day

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes

No

Since your last COVID-19 vaccination, have you had a home or laboratory pregnancy test that was positive?

Yes

No

How is your health now compared to before your COVID-19 vaccination?

Better

About the same

Worse

Do you believe your health problems might be related to your COVID-19 vaccination?

Yes

No

6 Month Health Check-in

Survey Name	6 Month Health Check-in
Started	12 SEP 2021 23:42
Completed In	6.57 minutes

How are you feeling today?

Good

Fair

Poor

Since we last contacted you, have you experienced any new symptoms or health conditions?

Yes

No

Please describe the symptoms or health conditions.

Confirmed elevated sCD40L & CC5L, diagnosed platelet activation, vascular inflammation, encephalopathy still full disability, not medically cleared to drive. Negative nucleocapsid test, 6 months of testing confirming no underlying health conditions.

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other - please describe 100+ days of speech, physical therapy and vestibular therapy & more to come; still no help from CISA after 6 months of trying, still no response from CDC, no help from public health, no help from FDA, needs to be moved under NVICP

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes

No

Since your last COVID-19 vaccination, have you had a home or laboratory pregnancy test that was positive?

Yes

No

How is your health now compared to before your COVID-19 vaccination?

Better

About the same

Worse

Do you believe your health problems might be related to your COVID-19 vaccination?

Yes

No

Final Health Check-in

Survey Name	Final Health Check-in
Started	14 MAR 2022 21:20
Completed In	11.05 minutes

How are you feeling today?

Good

Fair

Poor

Since we last contacted you, have you experienced any new symptoms or health conditions?

Yes

No

Please describe the symptoms or health conditions.

Elevated sCD40L, VEGF (seen in hypoxia & thrombocytopenia), fusion with defective stereopsis, deficient saccades, light & sound sensitivity, dizziness, "presents like TBI," speech therapy, vision rehabilitation, debilitating fatigue, menstrual clotting

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other - please describe Speech therapy, osteopathic rehabilitation, neural-vision rehabilitation, vestibular therapy, 9 research studies, including specialist labs. Found S1 in non-classical monocytes 6 months post injection with negative nucleocapsid and negative PCR

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes

No

Since your last COVID-19 vaccination, have you had a home or laboratory pregnancy test that was positive?

Yes

No

How is your health now compared to before your COVID-19 vaccination?

Better

About the same

Worse

Do you believe your health problems might be related to your COVID-19 vaccination?

Yes

No