DePaul Symptom Questionnaire

This form is for illustrative purposes only. Please do not provide personal health information.

NOTE: This questionnaire is posted for illustrative purposes only. Please do not enter personal data into this survey.

Study ID Number

_____

Date

_____
(To enter a date, you can click on the calendar icon or type a date into the text box. If you type the date, please use the following format: mm-dd-yyyy)

1 What is your height (in inches)?

_____

2 What is your weight (in pounds)?

_____

3 Date of Birth

_____
(To enter a date, you can click on the calendar icon or type a date into the text box. If you type the date, please use the following format: mm-dd-yyyy)

4 Gender

◯ Male
◯ Female
◯ Other

5 To which of the following race(s) do you belong? (Select an answer by clicking inside the box)

☐ Black, African-American
☐ White
☐ American Indian or Alaska Native
☐ Asian or Pacific Islander
☐ Other

a. Specify Race

_____

6 Are you of Latino or Hispanic origin?

◯ Yes
◯ No

7 What is your current marital status?

◯ Married or living with partner
◯ Separated
◯ Widowed
◯ Divorced
◯ Never married

8 Do you have any children?

◯ Yes
◯ No

a. How many children do you have?

_____

b. How many of your children are under 18 years old?

_____

9 How many people live in your home?

_____

10 What grade or degree have you completed in school?

- ◯ Less than high school
- ◯ Some high school
- ◯ High school degree or GED
- ◯ Partial college (at least one year) or specialized training
- ◯ Standard college degree
- ◯ Graduate or professional degree including masters and doctorate

11 What is your current work status? (Check all that apply)

- ☐ On disability
- ☐ Student
- ☐ Homemaker
- ☐ Retired
- ☐ Unemployed
- ☐ Working part-time
- ☐ Working full-time

a. If you are on disability, for what condition do you receive disability compensation? (Please Specify)

_____

12 What is your current occupation?

_____

a. If you are currently not working, what was your most recent occupation?

_____

For the following questions (13-66), we would like to know how often you have had each symptom and how much each symptom has bothered you over the last 6 months. For each symptom please select one number for frequency and one number for severity.

13 Fatigue / Extreme tiredness

Frequency: Throughout the past 6 months how often have you had fatigue / extreme tiredness?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has fatigue / extreme tiredness bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

14 Dead, heavy feeling after starting to exercise

Frequency: Throughout the past 6 months how often have you had a dead, heavy feeling after starting to exercise?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has a dead, heavy feeling after starting to exercise bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

15 Next day soreness or fatigue after non-strenuous, everyday activities

Frequency: Throughout the past 6 months, how often have you had next day soreness or fatigue after non-strenuous, everyday activities?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has next day soreness or fatigue after non-strenuous, everyday activities bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

16 Mentally tired after the slightest effort

Frequency: Throughout the past 6 months, how often have you felt mentally tired after the slightest effort?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time

Severity: Throughout the past 6 months, how much has feeling mentally tired after the slightest effort bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

17 Minimum exercise makes you physically tired

Frequency: Throughout the past 6 months, how often has minimum exercise made you physically tired?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has minimum exercise making you physically tired bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

18 Physically drained or sick after mild activity

Frequency: Throughout the past 6 months, how often have you felt physically drained or sick after mild activity?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has feeling physically drained or sick after mild activity bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

19 Feeling unrefreshed after you wake up in the morning

Frequency: Throughout the past 6 months, how often have you felt unrefreshed after you wake up in the morning?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has feeling unrefreshed after you wake up in the morning bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

20 Need to nap daily

Frequency: Throughout the past 6 months, how often have you needed to nap daily?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time

Severity: Throughout the past 6 months, how much has needing to nap daily bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

21 Problems falling asleep

Frequency: Throughout the past 6 months, how often have you had problems falling asleep?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much have problems falling asleep bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

22 Problems staying asleep

Frequency: Throughout the past 6 months, how often have you had problems staying asleep?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much have problems staying asleep bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

23 Waking up early in the morning (e.g. 3am)

Frequency: Throughout the past 6 months, how often have you woken up early in the morning (e.g. 3am)?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has waking up early in the morning (e.g. 3am) bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

24 Sleep all day and stay awake all night

Frequency: Throughout the past 6 months, how often have you slept all day and stayed awake all night?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time

Severity: Throughout the past 6 months, how much has sleeping all day and staying awake all night bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

25 Pain or aching in your muscles

Frequency: Throughout the past 6 months, how often have you had pain or aching in your muscles?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has pain or aching in your muscles bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

26 Pain / stiffness / tenderness in more than one joint without swelling or redness

Frequency: Throughout the past 6 months, how often have you had pain / stiffness / tenderness in more than one joint without swelling or redness?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has pain / stiffness / tenderness in more than one joint without swelling or redness bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

27 Eye pain

Frequency: Throughout the past 6 months, how often have you had eye pain?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has eye pain bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

28 Chest pain

Frequency: Throughout the past 6 months, how often have you had chest pain?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time

Severity: Throughout the past 6 months, how much has chest pain bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

29 Bloating

Frequency: Throughout the past 6 months, how often have you had bloating?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has bloating bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

30 Abdomen / Stomach pain

Frequency: Throughout the past 6 months, how often have you had abdomen / stomach pain?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has abdomen / stomach pain bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

31 Headaches

Frequency: Throughout the past 6 months, how often have you had headaches?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much have headaches bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

32 Muscle twitches

Frequency: Throughout the past 6 months, how often have you had muscle twitches?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time

Severity: Throughout the past 6 months, how much have muscle twitches bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

33 Muscle weakness

Frequency: Throughout the past 6 months, how often have you had muscle weakness?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has muscle weakness bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

34 Sensitivity to noise

Frequency: Throughout the past 6 months, how often have you had sensitivity to noise?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has sensitivity to noise bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

35 Sensitivity to bright lights

Frequency: Throughout the past 6 months, how often have you had sensitivity to bright lights?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has sensitivity to bright lights bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

36 Problems remembering things

Frequency: Throughout the past 6 months, how often have you had problems remembering things?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time

Severity: Throughout the past 6 months, how much have problems remembering things bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

37 Difficulty paying attention for a long period of time.

Frequency: Throughout the past 6 months, how often have you had difficulty paying attention for a long period of time?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has difficulty paying attention for a long period of time bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

38 Difficulty finding the right word to say or expressing thoughts

Frequency: Throughout the past 6 months, how often have you had difficulty finding the right word to say or expressing thoughts?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has difficulty finding the right word to say or expressing thoughts bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

39 Difficulty understanding things

Frequency: Throughout the past 6 months, how often have you had difficulty understanding things?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has difficulty understanding things bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

40 Only able to focus on one thing at a time

Frequency: Throughout the past 6 months, how often have you only been able to focus on one thing at a time?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time

Severity: Throughout the past 6 months, how much has only being able to focus on one thing at a time bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

41 Unable to focus vision and/or attention

Frequency: Throughout the past 6 months, how often have you been unable to focus vision and/or attention?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has being unable to focus vision and/or attention bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

42 Loss of depth perception

Frequency: Throughout the past 6 months, how often have you had loss of depth perception?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has loss of depth perception bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

43 Slowness of thought

Frequency: Throughout the past 6 months, how often have you had slowness of thought?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has slowness of thought bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

44 Absent-mindedness or forgetfulness

Frequency: Throughout the past 6 months, how often have you had absent-mindedness or forgetfulness?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time

Severity: Throughout the past 6 months, how much has absent-mindedness or forgetfulness bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

45 Bladder problems

Frequency: Throughout the past 6 months, how often have you had bladder problems?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much have bladder problems bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

46 Irritable bowel problems

Frequency: Throughout the past 6 months, how often have you had irritable bowel problems?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much have irritable bowel problems bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

47 Nausea

Frequency: Throughout the past 6 months, how often have you had nausea?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has nausea bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

48 Feeling unsteady on your feet, like you might fall

Frequency: Throughout the past 6 months, how often have you felt unsteady on your feet, like you might fall?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time

Severity: Throughout the past 6 months, how much has feeling unsteady on your feet, like you might fall bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

49 Shortness of breath or trouble catching your breath

Frequency: Throughout the past 6 months, how often have you had shortness of breath or trouble catching your breath?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has shortness of breath or trouble catching your breath bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

50 Dizziness or fainting

Frequency: Throughout the past 6 months, how often have you had dizziness or fainting?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has dizziness or fainting bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

51 Irregular heart beats

Frequency: Throughout the past 6 months, how often have you had irregular heartbeats?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much have irregular heartbeats bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

52 Losing or gaining weight without trying

Frequency: Throughout the past 6 months, how often have you lost or gained weight without trying?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time

Severity: Throughout the past 6 months, how much has losing or gaining weight without trying bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

53 No appetite

Frequency: Throughout the past 6 months how often have you had no appetite?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has having no appetite bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

54 Sweating hands

Frequency: Throughout the past 6 months, how often have you had sweating hands?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much have sweating hands bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

55 Night sweats

Frequency: Throughout the past 6 months, how often have you had night sweats?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much have night sweats bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

56 Cold limbs (e.g. arms, legs, hands)

Frequency: Throughout the past 6 months, how often have you had cold limbs (e.g. arms, legs, hands)?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time

Severity: Throughout the past 6 months, how much have cold limbs (e.g. arms, legs, hands) bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

57 Feeling chills or shivers

Frequency: Throughout the past 6 months, how often have you felt chills or shivers?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has feeling chills or shivers bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

58 Feeling hot or cold for no reason

Frequency: Throughout the past 6 months, how often have you felt hot or cold for no reason?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has feeling hot or cold for no reason bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

59 Feeling like you have a high temperature

Frequency: Throughout the past 6 months, how often have you felt like you have a high temperature?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has feeling like you have a high temperature bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

60 Feeling like you have a low temperature

Frequency: Throughout the past 6 months, how often have you felt like you have a low temperature?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time

Severity: Throughout the past 6 months, how much has feeling like you have a low temperature bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

61 Alcohol intolerance

Frequency: Throughout the past 6 months, how often have you had alcohol intolerance?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has alcohol intolerance bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

62 Sore throat

Frequency: Throughout the past 6 months, how often have you had sore throat?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has having a sore throat bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

63 Tender / Sore lymph nodes

Frequency: Throughout the past 6 months, how often have you had tender / sore lymph nodes?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much have tender / sore lymph nodes bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

64 Fever

Frequency: Throughout the past 6 months, how often have you had a fever?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time

Severity: Throughout the past 6 months, how much has having a fever bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

65 Flu-like symptoms

Frequency: Throughout the past 6 months, how often have you had flu-like symptoms?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much have flu-like symptoms bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

66 Some smells, foods, medication, or chemical make you feel sick

Frequency: Throughout the past 6 months, how often have some smells, foods, medications, or chemicals made you feel sick?	◯ 0 = none of the time ◯ 1 = a little of the time ◯ 2 = about half the time ◯ 3 = most of the time ◯ 4 = all of the time
Severity: Throughout the past 6 months, how much has having some smells, foods, medications, or chemicals make you feel sick bothered you?	◯ 0 = symptom not present ◯ 1 = mild ◯ 2 = moderate ◯ 3 = severe ◯ 4 = very severe

67 Have you always had persistent or recurring fatigue / energy problems, even back to your earliest memories as a child? (By persistent or recurring, we mean that the fatigue / energy problems are usually ongoing and constant, but sometimes there are good periods and bad periods.)

◯ Yes
◯ No
◯ Not having a problem with fatigue / energy

68 Since your fatigue / energy related illness began, do your headaches either happen more often, feel worse or more severe, or are they in a different place or spot?

◯ Yes
◯ No
◯ Not having a problem with fatigue / energy

69 How long ago did your problem with fatigue / energy begin?

◯ Less than 6 months
◯ 6-12 months
◯ 1-2 years
◯ Longer than 2 years
◯ Had problem with fatigue / energy since childhood or adolescence
◯ Not having a problem with fatigue / energy

70 Have you been diagnosed with Chronic Fatigue Syndrome or Myalgic Encephalomyelitis?

◯ Yes
◯ No

a. What year were you diagnosed?

_____

b. Do you currently have a diagnosis of Chronic Fatigue Syndrome or Myalgic Encephalomyelitis?

◯ Yes
◯ No

c. Who diagnosed you with Chronic Fatigue Syndrome or Myalgic Encephalomyelitis? (Check all that apply)

☐ Medical Doctor
☐ Alternative Practitioner
☐ Self-Diagnosed

d. Have any of your family members been diagnosed with Chronic Fatigue Syndrome or Myalgic Encephalomyelitis?

◯ Yes
◯ No

e. Please list their relation to you and current age

71 Did you experience any of the following symptoms regularly and repeatedly in the months and years before your fatigue / energy problems began? (Check all that apply)

☐ Sore throat
☐ Tender / Sore lymph nodes
☐ Unrefreshing sleep
☐ Impaired memory and concentration
☐ Prolonged fatigue following physical or mental exertion
☐ Muscle pain
☐ Headaches
☐ Joint Pain
☐ Not having a problem with fatigue / energy

72 If you rest, does your problem with fatigue / energy go away?

◯ Entirely
◯ Partially
◯ My fatigue / energy problem is not improved by rest
◯ I am not having a problem with fatigue / energy

a. How long do you have to rest for your problem with fatigue / energy to entirely or partially go away?

◯ Less than 30 minutes
◯ 30 - 59 minutes
◯ 1 - 2 hours
◯ More than 2 hours

73 If you were to become exhausted after actively participating in extracurricular activities, sports, or outgoings with friends, would you recover within an hour or two after the activity ended?

◯ Yes
◯ No

74 Do you reduce your activity level to avoid experiencing problems with fatigue / energy?

◯ Yes
◯ No
◯ Not having a problem with fatigue / energy

75 Do you experience worsening of your fatigue / energy related illness after engaging in minimal physical effort?

◯ Yes
◯ No
◯ Not having a problem with fatigue / energy

a. Do you experience a worsening of your fatigue / energy related illness after engaging in mental effort?

◯ Yes
◯ No

b. If you feel worse after activities, how long does this last?

◯ 1 hour or less
◯ 2 - 3 hours
◯ 4 - 10 hours
◯ 11 - 13 hours
◯ 14 - 23 hours
◯ More than 24 hours

c. Please specify

_____

76 Are you currently engaging in any form of exercise?

◯ Yes
◯ No

a. If you do not exercise, why aren't you exercising? (Check all that apply)

☐ Not interested
☐ No time
☐ Would like to but cannot because of problems with fatigue / energy
☐ Cannot because exercise makes symptoms worse

77 Over what period of time did your fatigue / energy related illness develop?

◯ Within 24 hours
◯ Over 1 week
◯ Over 1 month
◯ Over 2-6 months
◯ Over 7-12 months
◯ Over 1-2 years
◯ Over 3 or more years
◯ I am not ill

78 How would you describe the course of your fatigue / energy related illness?

◯ Constantly getting worse
◯ Constantly improving
◯ Persisting (no change)
◯ Relapsing & remitting (having "good" periods with no symptoms & "bad" periods)
◯ Fluctuating (symptoms periodically get better and get worse, but never disappear completely)
◯ No symptoms / I am not ill

79 Which statement best describes your fatigue / energy related illness during the last 6 months?

◯ I am not able to work or do anything, and I am bedridden.
◯ I can walk around the house, but I cannot do light housework.
◯ I can do light housework, but I cannot work part-time.
◯ I can only work part time at work or on some family responsibilities.
◯ I can work full time, but I have no energy left for anything else.
◯ I can work full time and finish some family responsibilities but I have no energy left for anything else.
◯ I can do all work or family responsibilities without any problems with my energy.

80 Did your fatigue / energy related illness start after you experienced any of the following? (Check all that apply)

☐ An infectious illness
☐ An accident
☐ A trip or vacation
☐ An immunization
☐ Surgery
☐ Sever stress (bad or unhappy event(s))
☐ Other
☐ I am not ill

Please describe the infectious illness that preceded your fatigue / energy related illness: _____

Please describe the accident that preceded your fatigue / energy related illness: _____

Please describe the trip or vacation that preceded your fatigue / energy related illness: _____

Please describe the immunization that preceded your fatigue / energy related illness: _____

Please describe the surgery that preceded your fatigue / energy related illness: _____

Please describe the severe stress (bad or unhappy event(s)) that preceded your fatigue / energy related illness: _____

80f Please describe what Other experience preceded your fatigue / energy related illness: _____

81 Have you ever consulted a medical doctor or health professional about your fatigue / energy problem?

◯ Yes
◯ No

82 Do you currently have a medical doctor overseeing your fatigue / energy problem?

◯ Yes
◯ No

83 Do you have any medical illness(es) that might be causing your symptoms?

◯ Yes
◯ No

a. What medical illness(es) do you have? Illness name(s) and year it began:

_____

b. For which of these conditions are you currently receiving treatment?

_____

84 Are you currently taking any medications (over the counter or prescription)?

◯ Yes
◯ No

a. What medications are you taking?

_____

85 Do you think any medication(s) is (are) causing your problem with fatigue / energy?

◯ Yes
◯ No
◯ I do not have a problem with fatigue / energy

85a Please specify which medication(s):

_____

86 Have you ever been diagnosed and/or treated for any of the following (Check all that apply):

☐ Major depression
☐ Major depression with melancholic features
☐ Bipolar disorder (manic-depression)
☐ Anxiety
☐ Schizophrenia
☐ Eating disorder
☐ Substance abuse
☐ Multiple chemical sensitivities
☐ Fibromyalgia
☐ Allergies
☐ Other
☐ No diagnosis / treatment

86a Major Depression (please write year(s) experienced, years treated, and medication (if applicable)):

_____

86b Major depression with melancholic features (please write year(s) experienced, years treated, and medication (if applicable)):

_____

86c Bipolar disorder (manic-depression) (please write year(s) experienced, years treated, and medication (if applicable)):

_____

86d Anxiety (please write year(s) experienced, years treated, and medication (if applicable)):

_____

86e Schizophrenia (please write year(s) experienced, years treated, and medication (if applicable)):

_____

86f Eating disorder (please write year(s) experienced, years treated, and medication (if applicable)):

_____

86g Substance abuse (please write year(s) experienced, years treated, and medication (if applicable)):

_____

86h Multiple Chemical sensitivities (please write year(s) experienced, years treated, and medication (if applicable)):

_____

86i Fibromyalgia (please write year(s) experienced, years treated, and medication (if applicable)):

_____

86j Allergies (please write year(s) experienced, years treated, and medication (if applicable)):

_____

86k Other (please write year(s) experienced, years treated, and medication (if applicable)):

_____

87 What do you think is the cause of your problem with fatigue / energy?

◯ Definitely physical
◯ Mainly physical
◯ Equally physical and psychological
◯ Mainly psychological
◯ Definitely psychological
◯ No problem with fatigue / energy

88 Do you think anything specific in your personal life or environment accounts for your problem with fatigue / energy?

◯ Yes
◯ No
◯ I do not have a problem with fatigue / energy

a. Please specify:

_____

89 In the past 4 weeks, approximately how many hours per week have you spent doing:

a. Household related activities? (hours per week):

_____
(Please type numbers (e.g., 0) and not words (e.g., zero).)

b. Social / Recreational related activities? (hours per week):

_____
(Please type numbers (e.g., 0) and not words (e.g., zero).)

c. Family related activities? (hours per week):

_____
(Please type numbers (e.g., 0) and not words (e.g., zero).)

d. Work related activities? (hours per week):

_____
(Please type numbers (e.g., 0) and not words (e.g., zero).)

90 In the past 4 weeks, have you had to reduce the number of hours you previously spent (prior to your illness) on occupational, social or family activities because of your health or problems with fatigue / energy?

◯ Yes
◯ No
◯ Not having a problem with fatigue / energy

a. Before your fatigue / energy related illness, approximately how many hours did you used to spend on: Household related activities? (hours per week)

_____
(Please type numbers (e.g., 0) and not words (e.g., zero).)

b. Before your fatigue / energy related illness, approximately how many hours did you used to spend on: Social/Recreational related activities (hours per week)

_____
(Please type numbers (e.g., 0) and not words (e.g., zero).)

c. Before your fatigue / energy related illness, approximately how many hours did you used to spend on: Family related activities? (hours per week)

_____
(Please type numbers (e.g., 0) and not words (e.g., zero).)

d. Before your fatigue / energy related illness, approximately how many hours did you used to spend on: Work related activities? (hours per week)

_____
(Please type numbers (e.g., 0) and not words (e.g., zero).)

91 Please rate the amount of energy you had available yesterday, using a scale from 1 to 100, where 1 = no energy and 100 = your pre-illness energy level. (If you don't have a fatigue / energy related illness a score of 100 = having abundant energy such that you could work full time and complete your family responsibilities)

_____
(Please type numbers (e.g., 1) and not words (e.g., one).)

92 Please rate the amount of energy you expended (used) yesterday, using a scale from 1 to 100, where 1 = no energy and 100 = your pre-illness energy level.

_____
(Please type numbers (e.g., 1) and not words (e.g., one).)

93 Please rate the amount of fatigue you had yesterday, using a scale from 1 to 100, where 1 = no fatigue and 100 = severe fatigue.

_____
(Please type numbers (e.g., 1) and not words (e.g., one).)

94 For the past week, please rate the amount of energy you had available using a scale from 1 to 100, where 1 = no energy and 100 = your pre-illness energy level.

_____
(Please type numbers (e.g., 1) and not words (e.g., one).)

95 For the past week, please rate the amount of energy you have expended (used) using a scale from 1 to 100, where 1 = no energy and 100 = your pre-illness energy level.

_____
(Please type numbers (e.g., 1) and not words (e.g., one).)

96 For the past week, please rate the amount of fatigue you have had using a scale from 1 to 100, where 1 = no fatigue and 100 = severe fatigue.

_____
(Please type numbers (e.g., 1) and not words (e.g., one).)

97 Since the onset of your problems with fatigue / energy, have your symptoms caused a 50% or greater reduction in your activity level?

◯ Yes
◯ No
◯ Not having a problem with fatigue / energy

98 Do you experience frequent viral infections with prolonged recovery periods?

◯ Yes
◯ No

99 Are you intolerant of extremes of temperatures (when it is extremely hot or cold)?

◯ Yes
◯ No

The remaining 36 questions comprise the RAND 36-Item Short Form Health Survey. This survey was developed at RAND as part of the Medical Outcomes Study.

1 In general, would you say your health is:

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

2 Compared to one year ago, how would your rate your health in general now?

- ◯ Much better now than one year ago
- ◯ Somewhat better now than one year ago
- ◯ About the same
- ◯ Somewhat worse now than one year ago
- ◯ Much worse now than one year ago

3 The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Choose one answer for each question.)

a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports

- ◯ Yes, limited a lot
- ◯ Yes, limited a little
- ◯ No, not limited at all

b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

- ◯ Yes, limited a lot
- ◯ Yes, limited a little
- ◯ No, not limited at all

c. Lifting or carrying groceries

- ◯ Yes, limited a lot
- ◯ Yes, limited a little
- ◯ No, not limited at all

d. Climbing several flights of stairs

- ◯ Yes, limited a lot
- ◯ Yes, limited a little
- ◯ No, not limited at all

e. Climbing one flight of stairs

- ◯ Yes, limited a lot
- ◯ Yes, limited a little
- ◯ No, not limited at all

f. Bending, kneeling, or stooping

- ◯ Yes, limited a lot
- ◯ Yes, limited a little
- ◯ No, not limited at all

g. Walking more than a mile

- ◯ Yes, limited a lot
- ◯ Yes, limited a little
- ◯ No, not limited at all

h. Walking several blocks

- ◯ Yes, limited a lot
- ◯ Yes, limited a little
- ◯ No, not limited at all

	i. Walking one block	◯ Yes, limited a lot ◯ Yes, limited a little ◯ No, not limited at all
	j. Bathing or dressing yourself	◯ Yes, limited a lot ◯ Yes, limited a little ◯ No, not limited at all
4	During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (Choose one answer for each question.)	
	a. Cut down the amount of time you spent on work or other activities	◯ Yes ◯ No
	b. Accomplished less than you would like	◯ Yes ◯ No
	c. Were limited in the kind of work or other activities	◯ Yes ◯ No
	d. Had difficulty performing the work or other activities (for example, it took extra effort)	◯ Yes ◯ No
5	During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? (Choose one answer for each question.)	
	a. Cut down the amount of time you spent on work or other activities	◯ Yes ◯ No
	b. Accomplished less than you would like	◯ Yes ◯ No
	c. Didn't do work or other activities as carefully as usual	◯ Yes ◯ No
6	During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (Choose one answer.)	◯ Not at all ◯ Slightly ◯ Moderately ◯ Quite a bit ◯ Extremely
7	How much bodily pain have you had during the past 4 weeks? (Choose one answer.)	◯ None ◯ Very mild ◯ Mild ◯ Moderate ◯ Severe ◯ Very severe
8	During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Choose one answer.)	◯ Not at all ◯ A little bit ◯ Moderately ◯ Quite a bit ◯ Extremely

9 These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . .(Choose one answer for each question.)

a. Did you feel full of pep?	◯ All of the time ◯ Most of the time ◯ A good bit of the time ◯ Some of the time ◯ A little of the time ◯ None of the time
b. Have you been a very nervous person?	◯ All of the time ◯ Most of the time ◯ A good bit of the time ◯ Some of the time ◯ A little of the time ◯ None of the time
c. Have you felt so down in the dumps that nothing could cheer you up?	◯ All of the time ◯ Most of the time ◯ A good bit of the time ◯ Some of the time ◯ A little of the time ◯ None of the time
d. Have you felt calm and peaceful?	◯ All of the time ◯ Most of the time ◯ A good bit of the time ◯ Some of the time ◯ A little of the time ◯ None of the time
e. Did you have a lot of energy?	◯ All of the time ◯ Most of the time ◯ A good bit of the time ◯ Some of the time ◯ A little of the time ◯ None of the time
f. Have you felt downhearted and blue?	◯ All of the time ◯ Most of the time ◯ A good bit of the time ◯ Some of the time ◯ A little of the time ◯ None of the time
g. Did you feel worn out?	◯ All of the time ◯ Most of the time ◯ A good bit of the time ◯ Some of the time ◯ A little of the time ◯ None of the time
h. Have you been a happy person?	◯ All of the time ◯ Most of the time ◯ A good bit of the time ◯ Some of the time ◯ A little of the time ◯ None of the time

	i. Did you feel tired?	◯ All of the time ◯ Most of the time ◯ A good bit of the time ◯ Some of the time ◯ A little of the time ◯ None of the time
10	During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? (Choose one option)	◯ All of the time ◯ Most of the time ◯ Some of the time ◯ A little of the time ◯ None of the time
11	How TRUE or FALSE is each of the following statements for you. (Choose one option for each question.)	
	a. I seem to get sick a little easier than other people	◯ Definitely true ◯ Mostly true ◯ Don't know ◯ Mostly false ◯ Definitely false
	b. I am as healthy as anybody I know	◯ Definitely true ◯ Mostly true ◯ Don't know ◯ Mostly false ◯ Definitely false
	c. I expect my health to get worse	◯ Definitely true ◯ Mostly true ◯ Don't know ◯ Mostly false ◯ Definitely false
	d. My health is excellent	◯ Definitely true ◯ Mostly true ◯ Don't know ◯ Mostly false ◯ Definitely false