

Form Approved
OMB No.
Expiration Date:

Attachment 6b

Provider Questionnaire (Knowledge, Attitudes, Beliefs)

<<Pre-Intervention>>

Public reporting burden of this collection of information is estimated to average 8 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or an other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX)

**Chronic Fatigue Syndrome
Health Care Provider Questionnaire**

1. Type of degree/certificate:

MD DO NP RN PA OT PT Masters (Specify):_____ Other (Specify):_____

2. Type of specialty (if applicable): _____

3. Type of setting you practice in:

Hospital Private Practice Group Practice Academic Community Other: _____

4. On average, how many patients do you usually see in a week? _____

5. How many new patients do you usually see in a 1 month period? _____

7. How many of those new patients usually become on-going patients in your practice? _____

8. Have you ever given a diagnosis of chronic fatigue syndrome (CFS)?

YES NO NOT APPLICABLE

9. Which of the following are necessary to make a diagnosis of CFS? (please circle TRUE or FALSE):

- | | | |
|---|------|-------|
| a. Fatigue lasting less than 6 months | TRUE | FALSE |
| b. Fatigue that significantly impact daily activities or work | TRUE | FALSE |
| c. Meeting 4 or more of the 8 CFS symptom criteria | TRUE | FALSE |
| d. Unique symptoms not seen in other illnesses | TRUE | FALSE |
| e. A neurological and psychological evaluation | TRUE | FALSE |
| f. Exclusionary laboratory tests | TRUE | FALSE |

10. In your opinion, which of the following are signs or symptoms of chronic fatigue syndrome?

Please circle YES or NO.

- | | | |
|---|-----|----|
| a. Post-exertional malaise. | YES | NO |
| b. Unrefreshing sleep. | YES | NO |
| c. Impaired memory or concentration | YES | NO |
| d. Muscle pain | YES | NO |
| e. Diarrhea | YES | NO |
| f. Multi-joint pain, without joint swelling or redness. | YES | NO |
| g. Headache | YES | NO |
| h. Tender cervical or axillary lymph nodes. | YES | NO |
| i. Sore throat | YES | NO |

