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Multi-Site Clinical Assessment of Chronic Fatigue Syndrome

SF-36 Health Survey

Participant ID Number: _____

Start Date: ____/____/____ & Time: ____am/pm
Month Day Year HH:MM

Complete Date: ____/____/____ & Time: ____am/pm
Month Day Year HH:MM

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1. In general, would you say your health is:

- ₁ Excellent
- ₂ Very Good
- ₃ Good
- ₄ Fair
- ₅ Poor

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

- ₁ Much better now than one year ago
- ₂ Somewhat better now than one year ago
- ₃ About the same as one year ago
- ₄ Somewhat worse now than one year ago
- ₅ 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?

Please mark the appropriate box.

	Yes, Limited A Lot ↓	Yes, Limited A Little ↓	No, Not Limited At All ↓
a. <i>Vigorous Activities</i> , such as running, lifting heavy objects, participating in strenuous sports.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
b. <i>Moderate Activities</i> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
c. Lifting or carrying groceries.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
d. Climbing <i>several</i> flights of stairs.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
e. Climbing <i>one</i> flight of stairs.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
f. Bending, kneeling, or stooping.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
g. Walking <i>more than a mile</i> .	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
h. Walking <i>several hundred yards</i> .	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
i. Walking <i>one hundred yards</i> .	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
j. Bathing or dressing yourself.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

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?

Please mark the appropriate box.

	<u>All of the Time</u> ↓	<u>Most of the Time</u> ↓	<u>Some of the Time</u> ↓	<u>A Little of the Time</u> ↓	<u>None of the Time</u> ↓
a. Cut down on the <i>amount of time</i> you spent on work or other activities	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
b. <i>Accomplished</i> less than you would like	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
c. Were limited in the <i>kind</i> of work or other activities	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
d. Had <i>difficulty</i> performing the work or other activities (for example, it took extra effort)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

5. During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)?

Please mark the appropriate box.

	<u>All of the Time</u> ↓	<u>Most of the Time</u> ↓	<u>Some of the Time</u> ↓	<u>A Little of the Time</u> ↓	<u>None of the Time</u> ↓
a. Cut down on the <i>amount of time</i> you spent on work or other activities	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
b. <i>Accomplished</i> less than you would like	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
c. Did work or activities <i>less carefully than usual</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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?

- ₁ Not at all
- ₂ Slightly
- ₃ Moderately
- ₄ Quite a bit
- ₅ Extremely

7. How much bodily pain have you had during the past 4 weeks?

- ₁ None
- ₂ Very mild
- ₃ Mild
- ₄ Moderate
- ₅ Severe
- ₆ Very severe

8. During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- ₁ None
- ₂ A little bit
- ₃ Moderately
- ₄ Quite a bit
- ₅ 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 four weeks...

Please mark the appropriate box.

	<u>All of the Time</u> ↓	<u>Most of the Time</u> ↓	<u>Some of the Time</u> ↓	<u>A Little Bit of the Time</u> ↓	<u>None of the Time</u> ↓
a. Did you feel full of life?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
b. Have you been very nervous?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
c. Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
d. Have you felt calm and peaceful?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
e. Did you have a lot of energy?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
f. Have you felt downhearted and depressed?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
g. Did you feel worn out?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
h. Have you been happy?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
i. Did you feel tired?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like as visiting friends, relatives, etc.)?

- ₁ All of the time
- ₂ Most of the time
- ₃ Some of the time
- ₄ A little of the time
- ₅ None of the time

11. How true or false is *each* of the following statements for you?

Please mark the appropriate box.

	Definitely True ↓	Mostly True ↓	Don't Know ↓	Mostly False ↓	Definitely False ↓
a. I seem to get sick a little easier than other people.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₈	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
b. I am as healthy as anybody I know.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₈	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
c. I expect my health to get worse.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₈	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
d. My health is excellent.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₈	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄