Form Approved
OMB Control No.: 0920-XXXX
Expiration date: 09/30/2023

17 b

Multi-Site Clinical Assessment of Chronic Fatigue Syndrome

Quality of Life (QoL)

For the 1st Follow-Up of CFS

Subject ID Number: _____

Start Date: _____/_____/_____ & Time: _____am/pm
Month Day Year HH:MM

Complete Date: _____/_____/_____ & Time: _____am/pm
Month Day Year HH:MM

Public reporting burden of this collection of information is estimated to average 3 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 any 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

QUALITY OF LIFE – UNHEALTHY DAYS

1. Now thinking about your physical health, which includes physical illness and injury, for about how many days during the past 30 days was your physical health not good?

__ __DAYS (RANGE=1-30)

88 NONE

97 DON'T KNOW/ NOT SURE

99 REFUSED

2. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

__ __DAYS (RANGE=1-30)

88 NONE

97 DON'T KNOW/ NOT SURE

99 REFUSED

CLINICAL GLOBAL IMPRESSION

3. Overall, how much has your health changed since you first came to the service?
   a. Very much better
   b. Much better
   c. A little better
   d. No change
   e. A little worse
   f. Much worse
   g. Very much worse

4. Please list the top three treatments, medications or management techniques that have impacted your health since coming to this service and rate how each has impacted your health.

Treatment/Medication/Management:	**How has your health changed since starting this treatment?**				
a. _____	☐ 1 Much Better	☐ 2 Somewhat better	☐ 3 About the Same	☐ 4 Somewhat Worse	☐ 5 Much Worse
b. _____	☐ 1 Much Better	☐ 2 Somewhat better	☐ 3 About the Same	☐ 4 Somewhat Worse	☐ 5 Much Worse
c. _____	☐ 1 Much Better	☐ 2 Somewhat better	☐ 3 About the Same	☐ 4 Somewhat Worse	☐ 5 Much Worse