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

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Multi-Site Clinical Assessment of Chronic Fatigue Syndrome

Quality of Life (QoL): with activity limitation questions

Subject ID Number: _____

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

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

QUALITY OF LIFE – UNHEALTHY DAYS AND ACTIVITY LIMITATION

1. Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone? (Include occasional use or use in certain circumstances.)

   1 YES

   2 NO

   7 DON'T KNOW/ NOT SURE

   9 REFUSED

2. 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

3. 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

4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

   __ __DAYS (RANGE=1-30)

   88 NONE

   97 DON'T KNOW/ NOT SURE

   99 REFUSED

NOW THINKING ABOUT YOUR HEALTH RECENTLY,

5. During the past week, were you able to care completely for yourself on a regular basis without any help?

   1 YES

   2 NO

   7 DON'T KNOW/ NOT SURE

   9 REFUSED

CLINICAL GLOBAL IMPRESSION

6. 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

7. 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

~ End of the Questionnaire ~