

11_d

Multi-Site Clinical Assessment of Chronic Fatigue Syndrome

CDC Symptom Inventory

Subject ID Number: _____

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

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

Symptom Checklist – Form A

1. In what month and year did your fatiguing illness begin?

Month _____ Year _____ (If you cannot remember, proceed to 1a.)

**1a. If you cannot remember the month and/or year in which your illness began:
Have you been experiencing this fatiguing illness for 6 months or longer?**

- 1 Yes
- 2 No
- 8 Don't know
- 7 Refused

2. When you are fatigued, does rest make your fatigue better?

- 1 Yes, a lot
- 2 Yes, a little
- 3 No, not very much
- 4 No, not at all

3. Has your fatiguing illness substantially limited your ability to pursue your usual job or occupation?

- 1 Yes
- 2 No
- 3 Not applicable

4. Has your fatiguing illness substantially limited your ability to pursue your usual educational activities?

- 1 Yes
- 2 No
- 3 Not applicable

5. Has your fatiguing illness substantially limited your social activities?

- 1 Yes
- 2 No
- 3 Not applicable

6. Has your fatiguing illness substantially limited your recreational activities?

- 1 Yes
- 2 No
- 3 Not applicable

CDC Symptom Inventory

These questions are about physical symptoms that you may have experienced during the past month.

Fatigue

C.1 During the past month, have you had fatigue, tiredness, or exhaustion?

- ₁ Yes
- ₂ No → (Skip to C.1f)

C.1a During the past month, how often have you had fatigue, tiredness or exhaustion?

- ₁ A little of the time
- ₂ Some of the time
- ₃ A good bit of the time
- ₄ Most of the time
- ₅ All of the time

C.1b During the past month, how bad was your fatigue, tiredness or exhaustion?

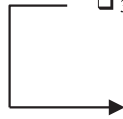
- ₁ Very mild
- ₂ Mild
- ₃ Moderate
- ₄ Severe
- ₅ Very severe

C.1c Prior to this past month, for how long had you had fatigue, tiredness or exhaustion?

₁ Less than 6 months → (Skip to C.1e)

₂ 6 – 12 months → (Skip to C.1e)

₃ More than 12 months



C.1d For how many years have you had fatigue, tiredness or exhaustion?

_____ Record Number of Years

C.1e Do you consider your fatigue, tiredness or exhaustion to currently be part of your ill-health?

₁ Yes

₂ No

C.1f Has fatigue, tiredness or exhaustion been a part of your ill-health in the past?

₁ Yes

₂ No

C.1g When this fatigue, tiredness, or exhaustion began, would you say that it came on all of a sudden, or slowly over time?

₁ All of sudden

₂ Slowly over time

₆ Not applicable

₈ Don't know

Sore Throat

C.2 During the past month, have you had a sore throat?

- ₁ Yes
- ₂ No \longrightarrow (Skip to C.3)

C.2a During the past month, how often have you had a sore throat?

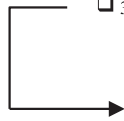
- ₁ A little of the time
- ₂ Some of the time
- ₃ A good bit of the time
- ₄ Most of the time
- ₅ All of the time

C.2b During the past month, how bad was your sore throat?

- ₁ Very mild
- ₂ Mild
- ₃ Moderate
- ₄ Severe
- ₅ Very severe

C.2c Prior to this past month, for how long had you had a sore throat?

- ₁ Less than 6 months \longrightarrow (Skip to C.3)
- ₂ 6 – 12 months \longrightarrow (Skip to C.3)
- ₃ More than 12 months

 **C.2d For how many years have you had a sore throat?**

_____ Record Number of Years

Tender Lymph Nodes and Swollen Glands

C.3 During the **past month**, have you had tender lymph nodes or swollen glands in your neck or armpits?

- ₁ Yes
₂ No → (Skip to C.4)

C.3a During the **past month**, how often have you had tender lymph nodes or swollen glands?

- ₁ A little of the time
₂ Some of the time
₃ A good bit of the time
₄ Most of the time
₅ All of the time

C.3b During the **past month**, how tender were your lymph nodes or how swollen were your glands?

- ₁ Very mild
₂ Mild
₃ Moderate
₄ Severe
₅ Very severe

C.3c Prior to this **past month**, how long had you had tender lymph nodes or swollen glands?

- ₁ Less than 6 months → (Skip to C.4)
₂ 6 – 12 months → (Skip to C.4)
₃ More than 12 months



C.3d For how many **years** have you had tender lymph nodes or swollen glands?

_____ Record Number of Years

Diarrhea

C.4 During the past month, have you had diarrhea?

- ₁ Yes
- ₂ No → (Skip to C.5)

C.4a During the past month, how often have you had diarrhea?

- ₁ A little of the time
- ₂ Some of the time
- ₃ A good bit of the time
- ₄ Most of the time
- ₅ All of the time

C.4b During the past month, how bad was your diarrhea?

- ₁ Very mild
- ₂ Mild
- ₃ Moderate
- ₄ Severe
- ₅ Very severe

C.4c Prior to this past month, for how long had you had diarrhea?

- ₁ Less than 6 months → (Skip to C.5)
- ₂ 6 – 12 months → (Skip to C.5)
- ₃ More than 12 months

→ **C.4d For how many years have you had diarrhea?**

_____ Record Number of Years

Fatigue After Exertion

C.5 During the past month, have you been unusually fatigued or unwell for at least one day after exerting yourself in any way?

- ₁ Yes
- ₂ No → (Skip to C.6)

C.5a During the past month, how often have you had unusual fatigue after exertion?

- ₁ A little of the time
- ₂ Some of the time
- ₃ A good bit of the time
- ₄ Most of the time
- ₅ All of the time

C.5b During the past month, how bad was your unusual fatigue after exertion?

- ₁ Very mild
- ₂ Mild
- ₃ Moderate
- ₄ Severe
- ₅ Very severe

C.5c Prior to this past month, for how long had you had unusual fatigue after exertion?

- ₁ Less than 6 months → (Skip to C.6)
- ₂ 6 – 12 months → (Skip to C.6)
- ₃ More than 12 months

→ **C.5d** For how many years have you had unusual fatigue after exertion?

_____ Record Number of Years

Muscle Aches and Pains

C.6 During the past month, have you had muscle aches or muscle pain?

- ₁ Yes
- ₂ No → (Skip to C.7)

C.6a During the past month, how often have you had muscle aches or muscle pains?

- ₁ A little of the time
- ₂ Some of the time
- ₃ A good bit of the time
- ₄ Most of the time
- ₅ All of the time

C.6b During the past month, how bad were your muscle aches or muscle pains?

- ₁ Very mild
- ₂ Mild
- ₃ Moderate
- ₄ Severe
- ₅ Very severe

C.6c Prior to this past month, for how long have you had muscle aches or muscle pains?

- ₁ Less than 6 months → (Skip to C.7)
- ₂ 6 – 12 months → (Skip to C.7)
- ₃ More than 12 months

→ **C.6d** For how many years have you had muscle aches or muscle pains?

_____ Record Number of Years

Joint Pain

C.7 During the past month, have you had pain in several joints?

- ₁ Yes
- ₂ No  **(Skip to C.8)**



C.7a During the past month, how often have you had joint pain?


- ₁ A little of the time
- ₂ Some of the time
- ₃ A good bit of the time
- ₄ Most of the time
- ₅ All of the time

C.7b During the past month, how bad was the joint pain?

- ₁ Very mild
- ₂ Mild
- ₃ Moderate
- ₄ Severe
- ₅ Very severe

C.7c Prior to this past month, for how long had you had joint pain?

- ₁ Less than 6 months  **(Skip to C.8)**
- ₂ 6 – 12 months  **(Skip to C.8)**
- ₃ More than 12 months

 **C.7d For how many years have you had joint pain?**

_____ Record Number of Years

Unrefreshing Sleep

C.8 During the **past month**, has unrefreshing sleep been a problem for you?

- ₁ Yes
- ₂ No → (Skip to C.9)

C.8a During the **past month**, how often have you had unrefreshing sleep?

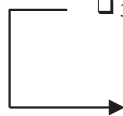
- ₁ A little of the time
- ₂ Some of the time
- ₃ A good bit of the time
- ₄ Most of the time
- ₅ All of the time

C.8b During the **past month**, how much of a problem was unrefreshing sleep?

- ₁ Very mild
- ₂ Mild
- ₃ Moderate
- ₄ Severe
- ₅ Very severe

C.8c Prior to this **past month**, for how long had you had unrefreshing sleep?

- ₁ Less than 6 months → (Skip to C.9)
- ₂ 6 – 12 months → (Skip to C.9)
- ₃ More than 12 months



C.8d For how many **years** have you had unrefreshing sleep?

_____ Record Number of Years

Sleeping Problems

C.9 During the past month, have you had problems getting to sleep, sleeping through the night, or waking up on time?

- ₁ Yes
₂ No → (Skip to C.10)

C.9a During the past month, how often have you had sleeping problems?

- ₁ A little of the time
₂ Some of the time
₃ A good bit of the time
₄ Most of the time
₅ All of the time

C.9b During the past month, how bad were these sleeping problems?

- ₁ Very mild
₂ Mild
₃ Moderate
₄ Severe
₅ Very severe

C.9c Prior to this past month, for how long had you had sleeping problems?

- ₁ Less than 6 months → (Skip to C.10)
₂ 6 – 12 months → (Skip to C.10)
₃ More than 12 months



C.9d For how many years have you had sleeping problems?

_____ Record Number of Years

Headaches

C.10 During the past month, have you had headaches?

- ₁ Yes
- ₂ No \longrightarrow (Skip to C.11)

C.10a During the past month, how often have you had headaches?

- ₁ A little of the time
- ₂ Some of the time
- ₃ A good bit of the time
- ₄ Most of the time
- ₅ All of the time

C.10b During the past month, how bad were your headaches?

- ₁ Very mild
- ₂ Mild
- ₃ Moderate
- ₄ Severe
- ₅ Very severe

C.10c Prior to this past month, for how long had you had headaches?

- ₁ Less than 6 months \longrightarrow (Skip to C.11)
 - ₂ 6 – 12 months \longrightarrow (Skip to C.11)
 - ₃ More than 12 months
- \longrightarrow **C.10d** For how many years have you headaches?

_____ Record Number of Years

Memory Problems

C.11 During the past month, have you had forgetfulness or memory problems that caused you to substantially cut back on your activities?

- ₁ Yes
- ₂ No → (Skip to C.12)

C.11a During the past month, how often have you had forgetfulness or memory problems?

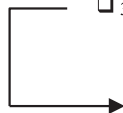
- ₁ A little of the time
- ₂ Some of the time
- ₃ A good bit of the time
- ₄ Most of the time
- ₅ All of the time

C.11b During the past month, how bad were your forgetfulness or memory problems?

- ₁ Very mild
- ₂ Mild
- ₃ Moderate
- ₄ Severe
- ₅ Very severe

C.11c Prior to this past month, for how long had you forgetfulness or memory problems?

- ₁ Less than 6 months → (Skip to C.12)
- ₂ 6 – 12 months → (Skip to C.12)
- ₃ More than 12 months



C.11d For how many years have you had forgetfulness or memory problems?

_____ Record Number of Years

Concentration

C.12 During the past month, have you had difficulty with thinking or concentrating that caused you to substantially cut back on your activities?

- ₁ Yes
- ₂ No → (Skip to C.13)

C.12a During the past month, how often have you had difficulty with thinking or concentrating?

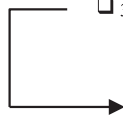
- ₁ A little of the time
- ₂ Some of the time
- ₃ A good bit of the time
- ₄ Most of the time
- ₅ All of the time

C.12b During the past month, how bad was your difficulty with thinking or concentrating?

- ₁ Very mild
- ₂ Mild
- ₃ Moderate
- ₄ Severe
- ₅ Very severe

C.12c Prior to this past month, for how long had you had difficulty with thinking or concentrating?

- ₁ Less than 6 months → (Skip to C.13)
- ₂ 6 – 12 months → (Skip to C.13)
- ₃ More than 12 months



C.12d For how many years have you had difficulty with thinking or concentrating?

_____ Record Number of Years

Nausea

C.13 During the past month, have you had nausea?

- ₁ Yes
- ₂ No \longrightarrow (Skip to C.14)

C.13a During the past month, how often have you had nausea?

- ₁ A little of the time
- ₂ Some of the time
- ₃ A good bit of the time
- ₄ Most of the time
- ₅ All of the time

C.13b During the past month, how bad was the nausea?

- ₁ Very mild
- ₂ Mild
- ₃ Moderate
- ₄ Severe
- ₅ Very severe

C.13c Prior to this past month, for how long had you had nausea?

- ₁ Less than 6 months \longrightarrow (Skip to C.14)
- ₂ 6 – 12 months \longrightarrow (Skip to C.14)
- ₃ More than 12 months

\longrightarrow **C.13d For how many years have you had nausea?**

_____ Record Number of Years

Stomach or Abdominal Pain

C.14 During the past month, have you had stomach or abdominal pain?

- ₁ Yes
- ₂ No → (Skip to C.15)

C.14a During the past month, how often have you had stomach or abdominal pain?

- ₁ A little of the time
- ₂ Some of the time
- ₃ A good bit of the time
- ₄ Most of the time
- ₅ All of the time

C.14b During the past month, how bad was your stomach or abdominal pain?

- ₁ Very mild
- ₂ Mild
- ₃ Moderate
- ₄ Severe
- ₅ Very severe

C.14c Prior to this past month, for how long had you had stomach or abdominal pain?

- ₁ Less than 6 months → (Skip to C.15)
- ₂ 6 – 12 months → (Skip to C.15)
- ₃ More than 12 months



C.14d For how many years have you had stomach or abdominal pain?

_____ Record Number of Years

Sinus or Nasal Problems

C.15 During the past month, have you had sinus or nasal symptoms?

- ₁ Yes
- ₂ No → (Skip to C.16)

C.15a During the past month, how often have you had sinus or nasal symptoms?

- ₁ A little of the time
- ₂ Some of the time
- ₃ A good bit of the time
- ₄ Most of the time
- ₅ All of the time

C.15b During the past month, how bad were your sinus or nasal symptoms?

- ₁ Very mild
- ₂ Mild
- ₃ Moderate
- ₄ Severe
- ₅ Very severe

C.15c Prior to this past month, for how long had you had sinus or nasal symptoms?

- ₁ Less than 6 months → (Skip to C.16)
- ₂ 6 – 12 months → (Skip to C.16)
- ₃ More than 12 months

→ **C.15d** For how many years have you had sinus or nasal symptoms?

_____ Record Number of Years

Shortness of Breath

C.16 During the past month, have you had shortness of breath?

- ₁ Yes
- ₂ No \longrightarrow (Skip to C.17)

C.16a During the past month, how often have you had shortness of breath?

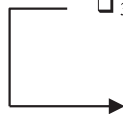
- ₁ A little of the time
- ₂ Some of the time
- ₃ A good bit of the time
- ₄ Most of the time
- ₅ All of the time

C.16b During the past month, how bad was your shortness of breath?

- ₁ Very mild
- ₂ Mild
- ₃ Moderate
- ₄ Severe
- ₅ Very severe

C.16c Prior to this past month, for how long had you had shortness of breath?

- ₁ Less than 6 months \longrightarrow (Skip to C.17)
- ₂ 6 – 12 months \longrightarrow (Skip to C.17)
- ₃ More than 12 months



C.16d For how many years have you had shortness of breath?

_____ Record Number of Years

Sensitivity to Light

C.17 During the past month, have your eyes been sensitive to light?

- ₁ Yes
- ₂ No → (Skip to C.18)

C.17a During the past month, how often have you been sensitive to light?

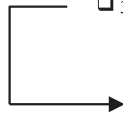
- ₁ A little of the time
- ₂ Some of the time
- ₃ A good bit of the time
- ₄ Most of the time
- ₅ All of the time

C.17b During the past month, how bad was your sensitivity to light?

- ₁ Very mild
- ₂ Mild
- ₃ Moderate
- ₄ Severe
- ₅ Very severe

C.17c Prior to this past month, for how long have you been sensitive to light?

- ₁ Less than 6 months → (Skip to C.18)
- ₂ 6 – 12 months → (Skip to C.18)
- ₃ More than 12 months



C.17d For how many years have you been sensitive to light?

_____ Record Number of Years

Depression

C.18 During the past month, have you been depressed?

- ₁ Yes
- ₂ No → (Skip to C.19)

C.18a During the past month, how often have you been depressed?

- ₁ A little of the time
- ₂ Some of the time
- ₃ A good bit of the time
- ₄ Most of the time
- ₅ All of the time

C.18b During the past month, how bad was the depression?

- ₁ Very mild
- ₂ Mild
- ₃ Moderate
- ₄ Severe
- ₅ Very severe

C.18c Prior to this past month, for how long had you been depressed?

- ₁ Less than 6 months → (Skip to C.19)
- ₂ 6 – 12 months → (Skip to C.19)
- ₃ More than 12 months

→ **C.18d** For how many years have you had problems with depression?

_____ Record Number of Years

Other Symptoms

C.19 During the past month, have any other symptoms in addition to those we have already asked about been part of your ill-health?

- ₁ Yes
- ₂ No —→ (Skip to C.20)

C.19a What other symptoms have been part of your ill-health during the past month?

Please specify the symptoms using the spaces below.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

C.20 Which of the following symptoms has bothered you the most during the past month?

Please **check only one box** that describes that symptom that bothered you most during the past month.

- 1 Fatigue, tiredness, or exhaustion
- 2 Sore throat
- 3 Tender lymph nodes or swollen glands in your neck or armpits
- 4 Diarrhea
- 5 Unusual fatigue for at least one day after exertion
- 6 Muscle aches or pains
- 7 Joint pain
- 8 Unrefreshing sleep
- 9 Sleeping problems
- 10 Headaches
- 11 Forgetfulness or memory problems
- 12 Difficulty thinking or concentrating
- 13 Nausea
- 14 Stomach or abdominal pains
- 15 Sinus or nasal symptoms
- 16 Shortness of breath
- 17 Eye sensitivity to light
- 18 Depression
- 19 Another symptom (Please specify: _____)