Form Approved
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11a

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 <u>past month</u>.

Fatigue

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

- ❑ 1 Yes
- ❑ 2 No ⟶ **(Skip to C.1f)**

C.1a During the <u>past month</u>, 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 <u>past month</u>, 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 → **(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 → **(Skip to C.3)**
- ❑ 2 6 – 12 months → **(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

Fever

C.8 During the past month, have you had a fever?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.9)**

C.8a During the past month, how often have you had a fever?

- ❑ 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 bad was your fever?

- ❑ 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 a fever?

- ❑ 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 a fever?**

_____ Record Number of Years

Chills

C.9 During the past month, have you had chills?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.10)**

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

- ❑ 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 your chills?

- ❑ 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 chills?

- ❑ 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 chills?**

_____ Record Number of Years

Unrefreshing Sleep

C.10 During the past month, has unrefreshing sleep been a problem for you?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.11)**

C.10a 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.10b 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.10c Prior to this past month, for how long had you had unrefreshing sleep?

- ❑ 1 Less than 6 months → **(Skip to C.11)**
- ❑ 2 6 – 12 months → **(Skip to C.11)**
- ❑ 3 More than 12 months

→ **C.10d For how many years have you had unrefreshing sleep?**

_____ Record Number of Years

Sleeping Problems

C.11 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.12)**

C.11a 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.11b During the past month, how bad were these sleeping 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 had sleeping 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 sleeping problems?

_____ Record Number of Years

Headaches

C.12 During the past month, have you had headaches?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.13)**

C.12a 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.12b During the past month, how bad were your headaches?

- ❑ 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 headaches?

- ❑ 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 headaches?**

_____ Record Number of Years

Memory Problems

C.13 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.14)**

C.13a 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.13b 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.13c Prior to this past month, for how long had you forgetfulness or memory problems?

- ❑ 1 Less than 6 months → **(Skip to C.14)**
- ❑ 2 6 – 12 months → **(Skip to C.14)**
- ❑ 3 More than 12 months

C.13d For how many years have you had forgetfulness or memory problems?

_____ Record Number of Years

Concentration

C.14 During the <u>past month</u>, 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.15)**

C.14a During the <u>past month</u>, 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.14b During the <u>past month</u>, how bad was your difficulty with thinking or concentrating?

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

C.14c Prior to this <u>past month</u>, for how long had you had difficulty with thinking or concentrating?

- ❑ 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 <u>years</u> have you had difficulty with thinking or concentrating?

_____ Record Number of Years

Nausea

C.15 During the past month, have you had nausea?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.16)**

C.15a 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.15b During the past month, how bad was the nausea?

- ❑ 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 nausea?

- ❑ 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 nausea?**

_____ Record Number of Years

Stomach or Abdominal Pain

C.16 During the past month, have you had stomach or abdominal pain?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.17)**

C.16a 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.16b 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.16c Prior to this past month, for how long had you had stomach or abdominal pain?

- ❑ 1 Less than 6 months → **(Skip to C.17)**
- ❑ 2 6 – 12 months → **(Skip to C.17)**
- ❑ 3 More than 12 months

C.16d For how many years have you had stomach or abdominal pain?

_____ Record Number of Years

Sinus or Nasal Problems

C.17 During the past month, have you had sinus or nasal symptoms?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.18)**

C.17a 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.17b 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.17c Prior to this past month, for how long had you had sinus or nasal symptoms?

- ❑ 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 had sinus or nasal symptoms?

_____ Record Number of Years

Shortness of Breath

C.18 During the past month, have you had shortness of breath?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.19)**

C.18a 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.18b During the past month, how bad was your shortness of breath?

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

C.18c Prior to this past month, for how long had you had shortness of breath?

- ❑ 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 shortness of breath?**

_____ Record Number of Years

Sensitivity to Light

C.19 During the past month, have your eyes been sensitive to light?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.20)**

C.19a 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.19b During the past month, how bad was your sensitivity to light?

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

C.19c Prior to this past month, for how long have you been sensitive to light?

- ❑ 1 Less than 6 months → **(Skip to C.20)**
- ❑ 2 6 – 12 months → **(Skip to C.20)**
- ❑ 3 More than 12 months

→ **C.19d For how many years have you been sensitive to light?**

_____ Record Number of Years

Depression

C.20 During the past month, have you been depressed?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.21)**

C.20a 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.20b During the past month, how bad was the depression?

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

C.20c Prior to this past month, for how long had you been depressed?

- ❑ 1 Less than 6 months → **(Skip to C.21)**
- ❑ 2 6 – 12 months → **(Skip to C.21)**
- ❑ 3 More than 12 months

C.20d For how many years have you had problems with depression?

_____ Record Number of Years

Other Symptoms

C.21 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.22)**

C.21a 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.22 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 Fever
- ❑ 9 Chills
- ❑ 10 Unrefreshing sleep
- ❑ 11 Sleeping problems
- ❑ 12 Headaches
- ❑ 13 Forgetfulness or memory problems
- ❑ 14 Difficulty thinking or concentrating
- ❑ 15 Nausea
- ❑ 16 Stomach or abdominal pains
- ❑ 17 Sinus or nasal symptoms
- ❑ 18 Shortness of breath
- ❑ 19 Eye sensitivity to light
- ❑ 20 Depression
- ❑ 21 Another symptom (Please specify: _____)

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11b

Multi-Site Clinical Assessment of Chronic Fatigue Syndrome

Form B Symptom Checklist and 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 B

The following questions will ask about your "illness." By "illness", we mean the health condition for which you were primarily recruited to participate in this study.

1. In what month and year did your 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 illness for 6 months or longer?

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

2. When you are ill, does rest make your illness better?

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

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

- ❑ 1 Yes
- ❑ 2 No
- ❑ 3 Not applicable

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

- ❑ 1 Yes
- ❑ 2 No
- ❑ 3 Not applicable

5. Has your illness substantially limited your social activities?

- ❑ 1 Yes
- ❑ 2 No
- ❑ 3 Not applicable

6. Has your 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 <u>past month</u>.

Fatigue

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

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.1f)**

C.1a During the <u>past month</u>, 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 <u>past month</u>, 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 <u>past month</u>, 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 <u>years</u> have you had fatigue, tiredness or exhaustion?

_____ Record Number of Years

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

- ❑ 1 Yes
- ❑ 2 No

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

- ❑ 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 → **(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 → **(Skip to C.3)**
- ❑ 2 6 – 12 months → **(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 <u>past month</u>, have you had pain in several joints?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.8)**

C.7a During the <u>past month</u>, 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 <u>past month</u>, how bad was the joint pain?

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

C.7c Prior to this <u>past month</u>, 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 <u>years</u> have you had joint pain?

_____ Record Number of Years

Fever

C.8 During the past month, have you had a fever?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.9)**

C.8a During the past month, how often have you had a fever?

- ❑ 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 bad was your fever?

- ❑ 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 a fever?

- ❑ 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 a fever?**

_____ Record Number of Years

Chills

C.9 During the past month, have you had chills?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.10)**

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

- ❑ 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 your chills?

- ❑ 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 chills?

- ❑ 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 chills?**

_____ Record Number of Years

Unrefreshing Sleep

C.10 During the past month, has unrefreshing sleep been a problem for you?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.11)**

C.10a 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.10b 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.10c Prior to this past month, for how long had you had unrefreshing sleep?

- ❑ 1 Less than 6 months → **(Skip to C.11)**
- ❑ 2 6 – 12 months → **(Skip to C.11)**
- ❑ 3 More than 12 months

C.10d For how many years have you had unrefreshing sleep?

_____ Record Number of Years

Sleeping Problems

C.11 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.12)**

C.11a 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.11b During the past month, how bad were these sleeping 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 had sleeping 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 sleeping problems?

_____ Record Number of Years

Headaches

C.12 During the past month, have you had headaches?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.13)**

C.12a 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.12b During the past month, how bad were your headaches?

- ❑ 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 headaches?

- ❑ 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 headaches?

_____ Record Number of Years

Memory Problems

C.13 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.14)**

C.13a 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.13b 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.13c Prior to this past month, for how long had you forgetfulness or memory problems?

- ❑ 1 Less than 6 months → **(Skip to C.14)**
- ❑ 2 6 – 12 months → **(Skip to C.14)**
- ❑ 3 More than 12 months

→ **C.13d For how many years have you had forgetfulness or memory problems?**

_____ Record Number of Years

Concentration

C.14 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.15)**

C.14a 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.14b 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.14c Prior to this past month, for how long had you had difficulty with thinking or concentrating?

- ❑ 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 difficulty with thinking or concentrating?

_____ Record Number of Years

Nausea

C.15 During the past month, have you had nausea?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.16)**

C.15a 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.15b During the past month, how bad was the nausea?

- ❑ 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 nausea?

- ❑ 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 nausea?**

_____ Record Number of Years

Stomach or Abdominal Pain

C.16 During the past month, have you had stomach or abdominal pain?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.17)**

C.16a 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.16b 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.16c Prior to this past month, for how long had you had stomach or abdominal pain?

- ❑ 1 Less than 6 months → **(Skip to C.17)**
- ❑ 2 6 – 12 months → **(Skip to C.17)**
- ❑ 3 More than 12 months

C.16d For how many years have you had stomach or abdominal pain?

_____ Record Number of Years

Sinus or Nasal Problems

C.17 During the past month, have you had sinus or nasal symptoms?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.18)**

C.17a 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.17b 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.17c Prior to this past month, for how long had you had sinus or nasal symptoms?

- ❑ 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 had sinus or nasal symptoms?

_____ Record Number of Years

Shortness of Breath

C.18 During the past month, have you had shortness of breath?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.19)**

C.18a 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.18b During the past month, how bad was your shortness of breath?

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

C.18c Prior to this past month, for how long had you had shortness of breath?

- ❑ 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 shortness of breath?

_____ Record Number of Years

Sensitivity to Light

C.19 During the past month, have your eyes been sensitive to light?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.20)**

C.19a 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.19b During the past month, how bad was your sensitivity to light?

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

C.19c Prior to this past month, for how long have you been sensitive to light?

- ❑ 1 Less than 6 months → **(Skip to C.20)**
- ❑ 2 6 – 12 months → **(Skip to C.20)**
- ❑ 3 More than 12 months

C.19d For how many years have you been sensitive to light?

_____ Record Number of Years

Depression

C.20 During the past month, have you been depressed?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.21)**

C.20a 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.20b During the past month, how bad was the depression?

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

C.20c Prior to this past month, for how long had you been depressed?

- ❑ 1 Less than 6 months → **(Skip to C.21)**
- ❑ 2 6 – 12 months → **(Skip to C.21)**
- ❑ 3 More than 12 months

C.20d For how many years have you had problems with depression?

_____ Record Number of Years

Other Symptoms

C.21 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.22)**

C.21a 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.22 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 Fever
- ❑ 9 Chills
- ❑ 10 Unrefreshing sleep
- ❑ 11 Sleeping problems
- ❑ 12 Headaches
- ❑ 13 Forgetfulness or memory problems
- ❑ 14 Difficulty thinking or concentrating
- ❑ 15 Nausea
- ❑ 16 Stomach or abdominal pains
- ❑ 17 Sinus or nasal symptoms
- ❑ 18 Shortness of breath
- ❑ 19 Eye sensitivity to light
- ❑ 20 Depression
- ❑ 21 Another symptom (Please specify: _____)

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

11c

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

CDC Symptom Inventory

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

Fatigue

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

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.1f)**

C.1a During the <u>past month</u>, 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 <u>past month</u>, 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 <u>past month</u>, 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 <u>years</u> have you had fatigue, tiredness or exhaustion?

_____ Record Number of Years

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

- ❑ 1 Yes
- ❑ 2 No

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

- ❑ 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 → **(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 → **(Skip to C.3)**
- ❑ 2 6 – 12 months → **(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

Fever

C.8 During the past month, have you had a fever?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.9)**

C.8a During the past month, how often have you had a fever?

- ❑ 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 bad was your fever?

- ❑ 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 a fever?

- ❑ 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 a fever?**

_____ Record Number of Years

Chills

C.9 During the past month, have you had chills?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.10)**

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

- ❑ 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 your chills?

- ❑ 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 chills?

- ❑ 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 chills?**

_____ Record Number of Years

Unrefreshing Sleep

C.10 During the past month, has unrefreshing sleep been a problem for you?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.11)**

C.10a 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.10b 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.10c Prior to this past month, for how long had you had unrefreshing sleep?

- ❑ 1 Less than 6 months → **(Skip to C.11)**
- ❑ 2 6 – 12 months → **(Skip to C.11)**
- ❑ 3 More than 12 months

C.10d For how many years have you had unrefreshing sleep?

_____ Record Number of Years

Sleeping Problems

C.11 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.12)**

C.11a 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.11b During the past month, how bad were these sleeping 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 had sleeping 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 sleeping problems?

_____ Record Number of Years

Headaches

C.12 During the past month, have you had headaches?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.13)**

C.12a 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.12b During the past month, how bad were your headaches?

- ❑ 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 headaches?

- ❑ 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 headaches?

_____ Record Number of Years

Memory Problems

C.13 During the <u>past month</u>, have you had forgetfulness or memory problems that caused you to substantially cut back on your activities?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.14)**

C.13a During the <u>past month</u>, 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.13b During the <u>past month</u>, how bad were your forgetfulness or memory problems?

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

C.13c Prior to this <u>past month</u>, for how long had you forgetfulness or memory problems?

- ❑ 1 Less than 6 months → **(Skip to C.14)**
- ❑ 2 6 – 12 months → **(Skip to C.14)**
- ❑ 3 More than 12 months

→ **C.13d For how many <u>years</u> have you had forgetfulness or memory problems?**

_____ Record Number of Years

Concentration

C.14 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.15)**

C.14a 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.14b 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.14c Prior to this past month, for how long had you had difficulty with thinking or concentrating?

- ❑ 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 difficulty with thinking or concentrating?

_____ Record Number of Years

Nausea

C.15 During the past month, have you had nausea?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.16)**

C.15a 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.15b During the past month, how bad was the nausea?

- ❑ 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 nausea?

- ❑ 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 nausea?**

_____ Record Number of Years

Stomach or Abdominal Pain

C.16 During the past month, have you had stomach or abdominal pain?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.17)**

C.16a 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.16b 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.16c Prior to this past month, for how long had you had stomach or abdominal pain?

- ❑ 1 Less than 6 months → **(Skip to C.17)**
- ❑ 2 6 – 12 months → **(Skip to C.17)**
- ❑ 3 More than 12 months

C.16d For how many years have you had stomach or abdominal pain?

_____ Record Number of Years

Sinus or Nasal Problems

C.17 During the past month, have you had sinus or nasal symptoms?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.18)**

C.17a 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.17b 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.17c Prior to this past month, for how long had you had sinus or nasal symptoms?

- ❑ 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 had sinus or nasal symptoms?

_____ Record Number of Years

Shortness of Breath

C.18 During the past month, have you had shortness of breath?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.19)**

C.18a 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.18b During the past month, how bad was your shortness of breath?

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

C.18c Prior to this past month, for how long had you had shortness of breath?

- ❑ 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 shortness of breath?

_____ Record Number of Years

Sensitivity to Light

C.19 During the past month, have your eyes been sensitive to light?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.20)**

C.19a 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.19b During the past month, how bad was your sensitivity to light?

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

C.19c Prior to this past month, for how long have you been sensitive to light?

- ❑ 1 Less than 6 months → **(Skip to C.20)**
- ❑ 2 6 – 12 months → **(Skip to C.20)**
- ❑ 3 More than 12 months

C.19d For how many years have you been sensitive to light?

_____ Record Number of Years

Depression

C.20 During the past month, have you been depressed?

- ❑ 1 Yes
- ❑ 2 No → **(Skip to C.21)**

C.20a 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.20b During the past month, how bad was the depression?

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

C.20c Prior to this past month, for how long had you been depressed?

- ❑ 1 Less than 6 months → **(Skip to C.21)**
- ❑ 2 6 – 12 months → **(Skip to C.21)**
- ❑ 3 More than 12 months

C.20d For how many years have you had problems with depression?

_____ Record Number of Years

Other Symptoms

C.21 During the past month, have you experienced any other symptoms in addition to those we have already asked about?

- ❑ 1 Yes
- ❑ 2 No ⟶ **(Skip to C.22)**

C.21a What other symptoms have you experienced during the past month?

Please specify the symptoms using the spaces below.

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

C.22 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 Fever
- ❑ 9 Chills
- ❑ 10 Unrefreshing sleep
- ❑ 11 Sleeping problems
- ❑ 12 Headaches
- ❑ 13 Forgetfulness or memory problems
- ❑ 14 Difficulty thinking or concentrating
- ❑ 15 Nausea
- ❑ 16 Stomach or abdominal pains
- ❑ 17 Sinus or nasal symptoms
- ❑ 18 Shortness of breath
- ❑ 19 Eye sensitivity to light
- ❑ 20 Depression
- ❑ 21 Another symptom (Please specify: _____)
- ❑ 22 Not applicable; I have not had any symptoms

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

11d

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 <u>past month</u>.

Fatigue

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

- ❑ 1 Yes
- ❑ 2 No ⟶ **(Skip to C.1f)**

C.1a During the <u>past month</u>, 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 <u>past month</u>, 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 → **(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 → **(Skip to C.3)**
- ❑ 2 6 – 12 months → **(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 <u>past month</u>, 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 <u>past month</u>, 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 <u>past month</u>, how bad were these sleeping problems?

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

C.9c Prior to this <u>past month</u>, 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 <u>years</u> have you had sleeping problems?**

_____ Record Number of Years

Headaches

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

- ❑ 1 Yes
- ❑ 2 No → **(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 → **(Skip to C.11)**
- ❑ 2 6 – 12 months → **(Skip to C.11)**
- ❑ 3 More than 12 months

→ **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 → **(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 → **(Skip to C.14)**
- ❑ 2 6 – 12 months → **(Skip to C.14)**
- ❑ 3 More than 12 months

→ **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 → **(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 → **(Skip to C.17)**
- ❑ 2 6 – 12 months → **(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: _____)

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12

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

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

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

2. Compared <u>to one year ago</u>, 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.	*Vigorous Activities*, such as running, lifting heavy objects, participating in strenuous sports.	❑1	❑2	❑3
b.	*Moderate Activities*, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	❑1	❑2	❑3
c.	Lifting or carrying groceries.	❑1	❑2	❑3
d.	Climbing *several* flights of stairs.	❑1	❑2	❑3
e.	Climbing *one* flight of stairs.	❑1	❑2	❑3
f.	Bending, kneeling, or stooping.	❑1	❑2	❑3
g.	Walking *more than a mil*e.	❑1	❑2	❑3
h.	Walking *several hundred yards.*	❑1	❑2	❑3
i.	Walking *one hundred yards.*	❑1	❑2	❑3
j.	Bathing or dressing yourself.	❑1	❑2	❑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.

		All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time
a.	Cut down on the *amount of time* you spent on work or other activities	❑1	❑2	❑3	❑4	❑5
b.	*Accomplished* less than you would like	❑1	❑2	❑3	❑4	❑5
c.	Were limited in the *kind* of work or other activities	❑1	❑2	❑3	❑4	❑5
d.	Had *difficulty* performing the work or other activities (for example, it took extra effort)	❑1	❑2	❑3	❑4	❑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.

		All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time
a.	Cut down on the *amount of time* you spent on work or other activities	❑1	❑2	❑3	❑4	❑5
b.	*Accomplished* less than you would like	❑1	❑2	❑3	❑4	❑5
c.	Did work or activities *less carefully than usual*	❑1	❑2	❑3	❑4	❑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.

		All of the Time	Most of the Time	Some of the Time	A Little Bit of the Time	None of the Time
a.	Did you feel full of life?	❑1	❑2	❑3	❑4	❑5
b.	Have you been very nervous?	❑1	❑2	❑3	❑4	❑5
c.	Have you felt so down in the dumps that nothing could cheer you up?	❑1	❑2	❑3	❑4	❑5
d.	Have you felt calm and peaceful?	❑1	❑2	❑3	❑4	❑5
e.	Did you have a lot of energy?	❑1	❑2	❑3	❑4	❑5
f.	Have you felt downhearted and depressed?	❑1	❑2	❑3	❑4	❑5
g.	Did you feel worn out?	❑1	❑2	❑3	❑4	❑5
h.	Have you been happy?	❑1	❑2	❑3	❑4	❑5
i.	Did you feel tired?	❑1	❑2	❑3	❑4	❑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.	❑ 1	❑ 2	❑ 8	❑ 3	❑ 4
b. I am as healthy as anybody I know.	❑ 1	❑ 2	❑ 8	❑ 3	❑ 4
c. I expect my health to get worse.	❑ 1	❑ 2	❑ 8	❑ 3	❑ 4
d. My health is excellent.	❑ 1	❑ 2	❑ 8	❑ 3	❑ 4

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Multi-Site Clinical Assessment of Chronic Fatigue Syndrome

Multidimensional Fatigue Inventory (MFI)

Participant ID Number: _____

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

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

Multi-Dimensional Fatigue Inventory

The next questions are about how you have been feeling lately. Please place one "X" for each statement.

The more you agree with the statement, the more you should place an "X" in the direction of "yes, that is true." The more you disagree with the statement, the more you should place an X in the direction of "no, that is not true."

Take for example the statement: "I FEEL RELAXED."

If you think that this statement is entirely true, that you have been feeling relaxed lately, you would place an "X" in the box labeled "1."

yes, that is true ☒ ☐ ☐ ☐ ☐ no, that is not true
1 2 3 4 5

1. I feel fit. — yes, that is true ☐ ☐ ☐ ☐ ☐ no, that is not true (1 2 3 4 5)
2. Physically I feel only able to do a little. — yes, that is true ☐ ☐ ☐ ☐ ☐ no, that is not true (1 2 3 4 5)
3. I feel very active. — yes, that is true ☐ ☐ ☐ ☐ ☐ no, that is not true (1 2 3 4 5)
4. I feel like doing all sorts of nice things. — yes, that is true ☐ ☐ ☐ ☐ ☐ no, that is not true (1 2 3 4 5)
5. I feel tired. — yes, that is t rue ☐ ☐ ☐ ☐ ☐ no, that is not true (1 2 3 4 5)
6. I think I do a lot in a day. — yes, that is true ☐ ☐ ☐ ☐ ☐ no, that is not true (1 2 3 4 5)

7. When I am doing something, I can keep my thoughts on it.	yes, that is true	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	no, that is not true
8. Physically I can take on a lot.	yes, that is true	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	no, that is not true
9. I dread having to do things.	yes, that is true	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	no, that is not true
10. I think I do very little in a day.	yes, that is true	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	no, that is not true
11. I can concentrate well.	yes, that is true	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	no, that is not true
12. I am rested.	yes, that is true	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	no, that is not true
13. It takes a lot of effort to concentrate on things.	yes, that is true	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	no, that is not true
14. Physically I feel I am in a bad condition.	yes, that is true	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	no, that is not true
15. I have a lot of plans.	yes, that is true	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	no, that is not true
16. I tire easily.	yes, that is true	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	no, that is not true

17. I get little done.	yes, that is true	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	no, that is not true
18. I don't feel like doing anything.	yes, that is true	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	no, that is not true
19. My thoughts easily wander.	yes, that is true	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	no, that is not true
20. Physically I feel I am in an excellent condition.	yes, that is true	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	no, that is not true

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14

Multi-Site Clinical Assessment of Chronic Fatigue Syndrome

DePaul Symptom Questionnaire (DSQ)

Participant ID Number: _____

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

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

Subject ID _____ Date _____

Questions from the DePaul Symptom Questionnaire (DSQ)

Please answer the following questions.

For the following questions (13-66), we would like to know **how often you have had each symptom** and **how much each symptom has bothered you over the last 6 months**. For each symptom please select **one number for frequency and one number for severity.** Please fill the chart out from left to right.

Symptoms	*Frequency*: Throughout the **past 6 months, how often** have you had this symptom? For each symptom below, select a number from: **0 = none of the time** **1 = a little of the time** **2 = about half the time** **3 = most of the time** **4 = all of the time**					*Severity*: Throughout the **past 6 months, how much** has this symptom bothered you? For each symptom below, select a number from: **0 = symptom not present** **1 = mild** **2 = moderate** **3 = severe** **4 = very severe**				
	0	**1**	**2**	**3**	**4**	**0**	**1**	**2**	**3**	**4**
13) Fatigue/extreme tiredness	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
14) Dead, heavy feeling after starting to exercise	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
15) Next day soreness or fatigue after non-strenuous, everyday activities	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
16) Mentally tired after the slightest effort	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
17) Minimum exercise makes you physically tired	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
18) Physically drained or sick after mild activity	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
19) Feeling unrefreshed after you wake up in the morning	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
20) Need to nap daily	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
21) Problems falling asleep	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
22) Problems staying asleep	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
23) Waking up early in the morning (e.g. 3am)	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
24) Sleep all day and stay awake all night	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
25) Pain or aching in your muscles	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
26) Pain/stiffness/tenderness in more than one joint without swelling or redness	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
27) Eye pain	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
28) Chest pain	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
29) Bloating	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭

Symptoms	*Frequency*: Throughout the **past 6 months, how often** have you had this symptom? For each symptom below, select a number from: **0 = none of the time** **1 = a little of the time** **2 = about half the time** **3 = most of the time** **4 = all of the time**					*Severity*: Throughout the **past 6 months, how much** has this symptom bothered you? For each symptom below, select a number from: **0 = symptom not present** **1 = mild** **2 = moderate** **3 = severe** **4 = very severe**				
	0	**1**	**2**	**3**	**4**	**0**	**1**	**2**	**3**	**4**
30) Abdomen/stomach pain	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
31) Headaches	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
32) Muscle twitches	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
33) Muscle weakness	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
34) Sensitivity to noise	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
35) Sensitivity to bright lights	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
36) Problems remembering things	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
37) Difficulty paying attention for a long period of time	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
38) Difficulty finding the right word to say or express things	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
39) Difficulty understanding things	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
40) Only able to focus on one thing at a time	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
41) Unable to focus vision and/or attention	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
42) Loss of depth perception	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
43) Slowness of thought	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
44) Absent-mindedness or forgetfulness	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
45) Bladder problems	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
46) Irritable bowel problems	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
47) Nausea	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
48) Feeling unsteady on your feet, like you might fall	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
49) Shortness of breath or trouble catching your breath	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
50) Dizziness or fainting	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭

Symptoms	*Frequency*: Throughout the **past 6 months, how often** have you had this symptom? For each symptom below, select a number from: **0 = none of the time** **1 = a little of the time** **2 = about half the time** **3 = most of the time** **4 = all of the time**					*Severity*: Throughout the **past 6 months, how much** has this symptom bothered you? For each symptom below, select a number from: **0 = symptom not present** **1 = mild** **2 = moderate** **3 = severe** **4 = very severe**				
	0	**1**	**2**	**3**	**4**	**0**	**1**	**2**	**3**	**4**
51) Irregular heart beats	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
52) Losing or gaining weight without trying	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
53) No appetite	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
54) Sweating hands	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
55) Night sweats	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
56) Cold limbs (e.g. arms, legs, hands)	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
57) Feeling chills or shivers	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
58) Feeling hot or cold for no reason	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
59) Feeling like you have a high temperature	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
60) Feeling like you have a low temperature	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
61) Alcohol intolerance	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
62) Sore throat	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
63) Tender/sore lymph nodes	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
64) Fever	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
65) Flu-like symptoms	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
66) Some smells, foods, medications, or chemical make you feel sick	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭

67. Have you **always** had persistent or recurring **fatigue/energy problems**, even back to your earliest memories as a child? (By persistent or recurring, we mean that the fatigue/energy problems are usually ongoing and constant, but sometimes there are good periods and bad periods).

⬭ Yes ⬭ No ⬭ Not having a problem with fatigue/energy

68. Since your **fatigue/energy-related illness** began, do your headaches either happen more often, feel worse or more severe, or are they in a different place or spot?

⬭ Yes ⬭ No ⬭ Not having a problem with fatigue/energy

69. How long ago did your problem with **fatigue/energy** begin?

- ◯ Less than 6 months
- ◯ 6-12 months
- ◯ 1-2 years
- ◯ Longer than 2 years
- ◯ Had problem with fatigue/energy since childhood or adolescence
- ◯ Not having a problem with fatigue/energy

70. Have you been diagnosed with Chronic Fatigue Syndrome or Myalgic Encephalomyelitis?

◯ Yes ◯ No *(Skip to Question 70d)*

70a. If yes, what year were you diagnosed? _____

70b. Do you currently have a diagnosis of Chronic Fatigue Syndrome or Myalgic Encephalomyelitis?

◯ Yes ◯ No

70c. Who diagnosed you with Chronic Fatigue Syndrome or Myalgic Encephalomyelitis?

- ◯ Medical doctor
- ◯ Alternative Practitioner
- ◯ Self-Diagnosed

70d. Have any of your family members been diagnosed with Chronic Fatigue Syndrome or Myalgic Encephalomyelitis?

◯ Yes ◯ No

If yes, please list their relation to you and their current age

_____

_____

_____

71. Did you experience any of the following symptoms regularly and repeatedly in the months and years before your fatigue/energy problems?

- ◯ Sore throat
- ◯ Tender/sore lymph nodes
- ◯ Unrefreshing sleep
- ◯ Impaired memory and concentration
- ◯ Prolonged fatigue following physical or mental exertion
- ◯ Muscle pain
- ◯ Headaches
- ◯ Joint pain
- ◯ Not having a problem with fatigue/energy

72. If you rest, does your problem with **fatigue**/energy go away? **(Select one)**

- ◯ Entirely
- ◯ Partially
- ◯ My fatigue/energy problem in not improved by rest *(Skip to Question 73)*
- ◯ I am not having a problem with fatigue/energy *(Skip to Question 73)*

72a. How long do you have to rest for your problem with **fatigue/energy** to entirely or partially go away?

- ◯ Less than 30 minutes
- ◯ 30-59 minutes
- ◯ 1-2 hours
- ◯ More than 2 hours

73. If you were to become exhausted after participating in extracurricular activities, sports, or outings with friends, would you recover within an hour or two after the activity ended?

◯ Yes ◯ No

74. Do you reduce your activity level to avoid experiencing problems with **fatigue/energy**?

◯ Yes ◯ No ◯ Not having a problem with fatigue/energy

75. Do you experience a worsening of your **fatigue/energy related illness** after engaging in minimal physical effort?

◯ Yes ◯ No ◯ Not having a problem with fatigue/energy

75a. Do you experience a worsening of your **fatigue/energy related illness** after engaging in minimal mental effort?

◯ Yes ◯ No

75b. If you feel worse after activities, how long does this last? **(Check one)**

- ◯ 1 hour or less
- ◯ 2-3 hours
- ◯ 4-10 hours
- ◯ 11-13 hours
- ◯ 14-23 hours
- ◯ More than 24 hours (please specify length) _____

76. Are you currently engaging in any form of exercise?

◯ Yes *(Skip to Question 77)* ◯ No

76a. If you do not exercise, why aren't you exercising? **(Check all boxes that you agree with)**?

- ◯ Not interested
- ◯ No time
- ◯ Would like to but cannot because of problems with fatigue/energy
- ◯ Cannot because exercise makes symptoms worse

77. Over what period of time did your **fatigue/energy related illness** develop? **(Select one)**

- ◯ Within 24 hours
- ◯ Over 1 week
- ◯ Over 1 month
- ◯ Over 2-6 months
- ◯ Over 7-12 months
- ◯ Over 1-2 years
- ◯ Over 3 or more years
- ◯ I am not ill

78. How would you describe the course of your **fatigue/energy related illness? (Select one)**

- ◯ Constantly getting worse
- ◯ Constantly improving
- ◯ Persisting (no change)
- ◯ Relapsing & remitting (having "good" periods with no symptoms & "bad" periods)
- ◯ Fluctuating (symptoms periodically get better and get worse, but never disappear completely)
- ◯ No Symptoms/ I am not ill

79. Which statement best describes your **fatigue/energy related illness** during the **last 6 months**? **(Check one)**

- ◯ I am not able to work or do anything and am bedridden
- ◯ I can walk around the house, but I cannot do light housework
- ◯ I can do light housework, but I cannot work part-time
- ◯ I can only work part-time at work or on some family responsibilities
- ◯ I can work full time, but I have no energy left for anything else
- ◯ I can work full time and finish some family responsibilities but I have no energy left for anything else
- ◯ I can do all work and family responsibilities without any problems with my energy

80. Did your **fatigue/energy related illness** start after you experienced any of the following? **(Check one or more and please specify)**

- ◯ An infectious illness _____
- ◯ An accident _____
- ◯ A trip or vacation _____
- ◯ An immunization _____
- ◯ Surgery _____
- ◯ Severe stress (bad or unhappy event(s)) _____
- ◯ Other _____
- ◯ I am not ill

81. Have you ever consulted a medical doctor or health professional about your **fatigue/energy** problem?

◯ Yes ◯ No *(Skip to Question 83)*

82. Do you currently have a medical doctor overseeing your **fatigue/energy** problem?

◯ Yes ◯ No

83. Do you have any medical illness(es) that might be causing your symptoms?

◯ Yes ◯ No *(Skip to Question 84)*

83a. What medical illnesses do you have?

Illness name(s) and year it began

_____

_____

_____

83b. For which of these conditions are you currently receiving treatment?

_____

_____

_____

84. Are you currently taking any medication (over the counter or prescription)?

◯ Yes ◯ No *(Skip to Question 86)*

84a. What medication are you taking?

_____

85. Do you think any medication(s) is (are) causing your problem with **fatigue/energy**?

◯ Yes ◯ No *(Skip to Question 86)*
◯ Not having a problem with fatigue/energy *(Skip to Question 86)*

85a. Please specify which medications:

_____

86. Have you ever been diagnosed and/or treated for any of the following: **(Check all that apply and write year(s) experienced, years treated, and medication (if applicable) in the blank)**

◯ Major depression _____
◯ Major depression with melancholic features _____
◯ Bipolar disorder (manic-depression) _____
◯ Anxiety _____
◯ Schizophrenia _____
◯ Eating disorder _____
◯ Substance abuse _____
◯ Multiple chemical substances _____
◯ Fibromyalgia _____
◯ Allergies _____
◯ Other *(Please specify)* _____
◯ No diagnosis/treatment

87. What do you think is the cause of your problem with **fatigue/energy**? **(Select one)**

◯ Definitely physical
◯ Mainly physical
◯ Equally physical and psychological
◯ Mainly psychological
◯ Definitely psychological
◯ No problem with fatigue/energy

88. Do you think anything specific in your personal life or environment accounts for your problem with **fatigue/energy**?

◯ Yes ◯ No *(Skip to Question 89)*
◯ I do not have a problem with fatigue/energy *(Skip to Question 89)*

88a. Please specify:

_____

89. In the **past 4 weeks**, approximately how many hours per week have you spent doing:

- ◯ Household related activities? _____ hours per week
- ◯ Social/Recreational related activities? _____ hours per week
- ◯ Family related activities _____ hours per week
- ◯ Work related activities? _____ hours per week

90. In the **past 4 weeks**, have you had to reduce the number of hours you previously spent (prior to your illness) on occupational, social or family activities because of your health or problems with **fatigue/energy**?

- ◯ Yes ◯ No *(Skip to Question 91)*
- ◯ Not having a problem with fatigue/energy *(Skip to Question 91)*

90a. **Before your fatigue/energy related illness**, approximately how many hours did you used to spend on:

- ◯ Household related activities? _____ hours per week
- ◯ Social/Recreational related activities? _____ hours per week
- ◯ Family related activities _____ hours per week
- ◯ Work related activities? _____ hours per week

91. Please rate the amount of **energy** you had available **yesterday**, using a scale from 1 to 100 where 1 = no energy and 100 = your pre-illness energy level. **(If you don't have a fatigue/energy related illness, a score of 100= having abundant energy such that you could work full time and complete your family responsibilities)**

_____

92. Please rate the amount of **energy** you expended (used) yesterday, using a scale from 1 to 100 where 1 = no energy and 100 = your pre-illness energy expended

_____

93. Please rate the amount of **fatigue** you had **yesterday**, using a scale from 1 to 100 where 1 = no fatigue and 100 = severe fatigue

_____

94. For the **past week**, please rate the amount of **energy** you had available using a scale from 1 to 100 where 1 = no energy and 100 = your pre-illness energy expended

_____

95. For the **past week**, please rate the amount of **energy** you have expended (used) using a scale from 1 to 100 where 1 = no energy and 100 = your pre-illness energy expended

_____

96. For the **past week**, please rate the amount of **fatigue** you have had using a scale from 1 to 100 where 1 = no fatigue and 100 = severe fatigue

_____

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14b

Multi-Site Clinical Assessment of Chronic Fatigue Syndrome

DePaul Symptom Questionnaire (DSQ)

Subject ID Number: _____

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

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

Questions from the DePaul Symptom Questionnaire (DSQ)

Please answer the following questions.

For the following questions, we would like to know **how often you have had each symptom** and **how much each symptom has bothered you over the last 6 months**. For each symptom please select **one number for frequency and one number for severity.** Please fill the chart out from left to right.

Symptoms	*Frequency*: Throughout the **past 6 months, how often** have you had this symptom? For each symptom below, select a number from: **0 = none of the time** **1 = a little of the time** **2 = about half the time** **3 = most of the time** **4 = all of the time**					*Severity*: Throughout the **past 6 months, how much** has this symptom bothered you? For each symptom below, select a number from: **0 = symptom not present** **1 = mild** **2 = moderate** **3 = severe** **4 = very severe**				
	0	**1**	**2**	**3**	**4**	**0**	**1**	**2**	**3**	**4**
1) Dead, heavy feeling after starting to exercise	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
2) Next day soreness or fatigue after non-strenuous, everyday activities	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
3) Mentally tired after the slightest effort	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
4) Minimum exercise makes you physically tired	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
5) Physically drained or sick after mild activity	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
6) Muscle twitches	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
7) Muscle weakness	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
8) Sensitivity to noise	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
9) Bladder problems	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
10) Irritable bowel problems	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
11) Nausea	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
12) Feeling unsteady on your feet, like you might fall	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
13) Shortness of breath or trouble catching your breath	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
14) Dizziness or fainting	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
15) Irregular heart beats	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
16) Losing or gaining weight without trying	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
17) No appetite	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭

Symptoms	*Frequency*: Throughout the **past 6 months, how often** have you had this symptom? For each symptom below, select a number from: **0 = none of the time** **1 = a little of the time** **2 = about half the time** **3 = most of the time** **4 = all of the time**					*Severity*: Throughout the **past 6 months, how much** has this symptom bothered you? For each symptom below, select a number from: **0 = symptom not present** **1 = mild** **2 = moderate** **3 = severe** **4 = very severe**				
	0	**1**	**2**	**3**	**4**	**0**	**1**	**2**	**3**	**4**
18) Sweating hands	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
19) Night sweats	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
20) Cold limbs (e.g. arms, legs, hands)	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
21) Feeling chills or shivers	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
22) Feeling hot or cold for no reason	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
23) Feeling like you have a high temperature	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
24) Feeling like you have a low temperature	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
25) Alcohol intolerance	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
26) Some smells, foods, medications, or chemical make you feel sick	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭

THIS IS THE END OF THE SURVEY

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

14c

Multi-Site Clinical Assessment of Chronic Fatigue Syndrome

DePaul Symptom Questionnaire (DSQ)

Subject ID Number: _____

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

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

Questions from the DePaul Symptom Questionnaire (DSQ)

Please answer the following questions.

For the following questions, we would like to know **how often you have had each symptom** and **how much each symptom has bothered you over the last 6 months**. For each symptom please select **one number for frequency and one number for severity.** Please fill the chart out from left to right.

Symptoms	*Frequency*: Throughout the **past 6 months, how often** have you had this symptom? For each symptom below, select a number from: **0 = none of the time** **1 = a little of the time** **2 = about half the time** **3 = most of the time** **4 = all of the time**					*Severity*: Throughout the **past 6 months, how much** has this symptom bothered you? For each symptom below, select a number from: **0 = symptom not present** **1 = mild** **2 = moderate** **3 = severe** **4 = very severe**				
	0	**1**	**2**	**3**	**4**	**0**	**1**	**2**	**3**	**4**
1) Dead, heavy feeling after starting to exercise	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
2) Next day soreness or fatigue after non-strenuous, everyday activities	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
3) Mentally tired after the slightest effort	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
4) Minimum exercise makes you physically tired	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
5) Physically drained or sick after mild activity	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
6) Muscle twitches	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
7) Muscle weakness	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
8) Sensitivity to noise	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
9) Sensitivity to bright lights	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
10) Problems remembering things	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
11) Difficulty paying attention for a long period of time	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
12) Difficulty finding the right word to say or express things	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
13) Difficulty understanding things	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
14) Only able to focus on one thing at a time	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
15) Unable to focus vision and/or attention	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
16) Loss of depth perception	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
17) Slowness of thought	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
18) Absent-mindedness or forgetfulness	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭

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15a

Multi-Site Clinical Assessment of Chronic Fatigue Syndrome

PROMIS Instrument & Sleep Questions

Subject ID Number: _____

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

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

PROMIS Fatigue - Short Form 7a

Please respond to each item by marking one answer per question. In the past 7 days...

How often did you feel tired? ...	☐1 Never	☐2 Rarely	☐3 Sometimes	☐4 Often	☐5 Always
How often did you experience extreme exhaustion? ...	☐1 Never	☐2 Rarely	☐3 Sometimes	☐4 Often	☐5 Always
How often did you run out of energy? ...	☐1 Never	☐2 Rarely	☐3 Sometimes	☐4 Often	☐5 Always
How often did your fatigue limit you at work (include work at home)? ...	☐1 Never	☐2 Rarely	☐3 Sometimes	☐4 Often	☐5 Always
How often were you too tired to think clearly? ...	☐1 Never	☐2 Rarely	☐3 Sometimes	☐4 Often	☐5 Always
How often were you too tired to take a bath or shower? ...	☐1 Never	☐2 Rarely	☐3 Sometimes	☐4 Often	☐5 Always
How often did you have enough energy to exercise strenuously? ...	☐5 Never	☐4 Rarely	☐3 Sometimes	☐2 Often	☐1 Always

PROMIS Sleep Disturbance - Short Form 8b

Please respond to each item by marking one answer per question. In the past 7 days...

My sleep was restless...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
I was satisfied with my sleep...	☐ 5 Not at all	☐ 4 A little bit	☐ 3 Somewhat	☐ 2 Quite a bit	☐ 1 Very much
My sleep was refreshing...	☐ 5 Not at all	☐ 4 A little bit	☐ 3 Somewhat	☐ 2 Quite a bit	☐ 1 Very much
I had difficulty falling asleep...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
I had trouble staying asleep...	☐ 1 Never	☐ 2 Rarely	☐ 3 Sometimes	☐ 4 Often	☐ 5 Always
I had trouble sleeping…	☐ 1 Never	☐ 2 Rarely	☐ 3 Sometimes	☐ 4 Often	☐ 5 Always
I got enough sleep…	☐ 5 Never	☐ 4 Rarely	☐ 3 Sometimes	☐ 2 Often	☐ 1 Always
My sleep quality was…	☐ 5 Very poor	☐ 4 Poor	☐ 3 Fair	☐ 2 Good	☐ 1 Very good

PROMIS Sleep Related Impairment - Short Form 8a

Please respond to each item by marking one answer per question. In the past 7 days...

I had a hard time getting things done because I was sleepy...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
I felt alert when I woke up...	☐ 5 Not at all	☐ 4 A little bit	☐ 3 Somewhat	☐ 2 Quite a bit	☐ 1 Very much
I felt tired...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
I had problems during the day because of poor sleep…	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
I had a hard time concentrating because of poor sleep...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
I felt irritable because of poor sleep…	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
I was sleepy during the daytime…	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
I had trouble staying awake during the day…	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much

PROMIS Pain Interference - Short Form 6b

Please respond to each item by marking one answer per question. In the past 7 days...

How much did pain interfere with your enjoyment of life? ...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
How much did pain interfere with your ability to concentrate? ...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
How much did pain interfere with your day to day activities? ...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
How much did pain interfere with your enjoyment of recreational activities? ...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
How much did pain interfere with doing your tasks away from home (e.g., getting groceries, running errands)? ...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
How often did pain keep you from socializing with others? …	☐ 1 Never	☐ 2 Rarely	☐ 3 Sometimes	☐ 4 Often	☐ 5 Always

PROMIS Pain Behavior - Short Form 7a

Please respond to each item by marking one answer per question.

When I was in pain I became irritable...	☐ 1 Had no Pain	☐ 2 Never	☐ 3 Rarely	☐ 4 Sometimes	☐ 5 Often	☐ 6 Always
When I was in pain I grimaced...	☐ 1 Had no Pain	☐ 2 Never	☐ 3 Rarely	☐ 4 Sometimes	☐ 5 Often	☐ 6 Always
When I was in pain I moved extremely slowly...	☐ 1 Had no Pain	☐ 2 Never	☐ 3 Rarely	☐ 4 Sometimes	☐ 5 Often	☐ 6 Always
When I was in pain I moved stiffly…	☐ 1 Had no Pain	☐ 2 Never	☐ 3 Rarely	☐ 4 Sometimes	☐ 5 Often	☐ 6 Always
When I was in pain I called out for someone to help me...	☐ 1 Had no Pain	☐ 2 Never	☐ 3 Rarely	☐ 4 Sometimes	☐ 5 Often	☐ 6 Always
When I was in pain I isolated myself from others…	☐ 1 Had no Pain	☐ 2 Never	☐ 3 Rarely	☐ 4 Sometimes	☐ 5 Often	☐ 6 Always
When I was in pain I thrashed…	☐ 1 Had no Pain	☐ 2 Never	☐ 3 Rarely	☐ 4 Sometimes	☐ 5 Often	☐ 6 Always

Sleep Related Questions

Please answer the following questions about sleep. Most people sleep at night. If you work nights and sleep during the day, please consider the term "night" to mean the time in which you sleep.

1. On average, *during the past month*:

A. What time do you go to bed?	_____ : _____	☐ AM	☐ PM
B. What time do you fall asleep?	_____ : _____	☐ AM	☐ PM
C. What time do you wake up?	_____ : _____	☐ AM	☐ PM
D. What time do you get up?	_____ : _____	☐ AM	☐ PM

2. Do you read or watch television after getting into bed at night? ☐ 1 Yes ☐ 2 No

3. On average, *during the past month*, how many nights per week have you:

	Never	1 – 2 nights per week	3 – 5 nights per week	6 – 7 nights per week
A. Experienced difficulty falling asleep?	❑ 1	❑ 2	❑ 3	❑ 4
B. Experienced difficulty sleeping through the night because you wake up and cannot go back to sleep?	❑ 1	❑ 2	❑ 3	❑ 4
C. Awakened earlier than you wanted to and did not get enough sleep?	❑ 1	❑ 2	❑ 3	❑ 4
D. Woken up from a night's sleep not feeling rested?	❑ 1	❑ 2	❑ 3	❑ 4
E. Experienced nightmares or disturbing dreams?	❑ 1	❑ 2	❑ 3	❑ 4
F. Awakened to find that you had messed up the sheets?	❑ 1	❑ 2	❑ 3	❑ 4

4. Do you know, or have you ever been told, that you snore loudly during sleep?
- ☐ 1 Yes
- ☐ 2 No **(SKIP TO QUESTION 6)**

5. On average, how often do you snore?
- ☐ 1 Never
- ☐ 2 1-3 nights per week
- ☐ 3 4-5 nights per week
- ☐ 4 6-7 nights per week

6. Do you know, or have you ever been told, that your breathing pauses during sleep?
- ☐ 1 Yes
- ☐ 2 No

7. How often do you get so sleepy during the day or evening that you have to take a nap?
- ☐ 1 Never
- ☐ 2 Once a month or less
- ☐ 3 2-4 times per month
- ☐ 4 5-15 times per month
- ☐ 5 More than 15 times per month

8. When sitting inactive or lying down, do you experience a strong urge to move your legs that is accompanied by unpleasant sensations, such as, restlessness, creepy-crawling or tingly feelings?
- ☐ 1 Never **(SKIP TO QUESTION 11)**
- ☐ 2 Once a month or less
- ☐ 3 2-4 times per month
- ☐ 4 5-15 times per month
- ☐ 5 More than 15 times per month

9. Are the unpleasant feelings in your legs made better in any way, even temporarily or for a short time, by walking or moving your legs?
- ☐ 1 Yes
- ☐ 2 No

10. If these sensations and urges to move bother you, when do they most bother you? ***Please mark all that apply***.

- ☐ 1 Morning
- ☐ 2 Day
- ☐ 3 Evening
- ☐ 4 Night
- ☐ 5 These sensations do not bother me

11. On average, how often do your legs jerk or move by themselves while lying down and attempting to go to sleep?

- ☐ 1 Never
- ☐ 2 Once a month or less
- ☐ 3 2-4 times per month
- ☐ 4 5-15 times per month
- ☐ 5 More than 15 times per month

12. On average, how often do your legs jerk while you are asleep?

- ☐ 1 Never
- ☐ 2 Once a month or less
- ☐ 3 2-4 times per month
- ☐ 4 5-15 times per month
- ☐ 5 More than 15 times per month

~ End of Questionnaire ~

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

15b

Multi-Site Clinical Assessment of Chronic Fatigue Syndrome

PROMIS Instrument

Subject ID Number: _____

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

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

PROMIS Fatigue - Short Form 7a

Please respond to each item by marking one answer per question. In the past 7 days...

How often did you feel tired? ...	☐1 Never	☐2 Rarely	☐3 Sometimes	☐4 Often	☐5 Always
How often did you experience extreme exhaustion? ...	☐1 Never	☐2 Rarely	☐3 Sometimes	☐4 Often	☐5 Always
How often did you run out of energy? ...	☐1 Never	☐2 Rarely	☐3 Sometimes	☐4 Often	☐5 Always
How often did your fatigue limit you at work (include work at home)? ...	☐1 Never	☐2 Rarely	☐3 Sometimes	☐4 Often	☐5 Always
How often were you too tired to think clearly? ...	☐1 Never	☐2 Rarely	☐3 Sometimes	☐4 Often	☐5 Always
How often were you too tired to take a bath or shower? ...	☐1 Never	☐2 Rarely	☐3 Sometimes	☐4 Often	☐5 Always
How often did you have enough energy to exercise strenuously? ...	☐5 Never	☐4 Rarely	☐3 Sometimes	☐2 Often	☐1 Always

PROMIS Sleep Disturbance - Short Form 8b

Please respond to each item by marking one answer per question. In the past 7 days...

My sleep was restless...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
I was satisfied with my sleep...	☐ 5 Not at all	☐ 4 A little bit	☐ 3 Somewhat	☐ 2 Quite a bit	☐ 1 Very much
My sleep was refreshing...	☐ 5 Not at all	☐ 4 A little bit	☐ 3 Somewhat	☐ 2 Quite a bit	☐ 1 Very much
I had difficulty falling asleep...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
I had trouble staying asleep...	☐ 1 Never	☐ 2 Rarely	☐ 3 Sometimes	☐ 4 Often	☐ 5 Always
I had trouble sleeping…	☐ 1 Never	☐ 2 Rarely	☐ 3 Sometimes	☐ 4 Often	☐ 5 Always
I got enough sleep…	☐ 5 Never	☐ 4 Rarely	☐ 3 Sometimes	☐ 2 Often	☐ 1 Always
My sleep quality was…	☐ 5 Very poor	☐ 4 Poor	☐ 3 Fair	☐ 2 Good	☐ 1 Very good

PROMIS Sleep Related Impairment - Short Form 8a

Please respond to each item by marking one answer per question. In the past 7 days...

I had a hard time getting things done because I was sleepy...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
I felt alert when I woke up...	☐ 5 Not at all	☐ 4 A little bit	☐ 3 Somewhat	☐ 2 Quite a bit	☐ 1 Very much
I felt tired...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
I had problems during the day because of poor sleep…	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
I had a hard time concentrating because of poor sleep...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
I felt irritable because of poor sleep…	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
I was sleepy during the daytime…	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
I had trouble staying awake during the day…	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much

PROMIS Pain Interference - Short Form 6b

Please respond to each item by marking one answer per question. In the past 7 days...

How much did pain interfere with your enjoyment of life? ...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
How much did pain interfere with your ability to concentrate? ...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
How much did pain interfere with your day to day activities? ...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
How much did pain interfere with your enjoyment of recreational activities? ...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
How much did pain interfere with doing your tasks away from home (e.g., getting groceries, running errands)? ...	☐ 1 Not at all	☐ 2 A little bit	☐ 3 Somewhat	☐ 4 Quite a bit	☐ 5 Very much
How often did pain keep you from socializing with others? …	☐ 1 Never	☐ 2 Rarely	☐ 3 Sometimes	☐ 4 Often	☐ 5 Always

PROMIS Pain Behavior - Short Form 7a

Please respond to each item by marking one answer per question.

When I was in pain I became irritable...	☐ 1 Had no Pain	☐ 2 Never	☐ 3 Rarely	☐ 4 Sometimes	☐ 5 Often	☐ 6 Always
When I was in pain I grimaced...	☐ 1 Had no Pain	☐ 2 Never	☐ 3 Rarely	☐ 4 Sometimes	☐ 5 Often	☐ 6 Always
When I was in pain I moved extremely slowly...	☐ 1 Had no Pain	☐ 2 Never	☐ 3 Rarely	☐ 4 Sometimes	☐ 5 Often	☐ 6 Always
When I was in pain I moved stiffly…	☐ 1 Had no Pain	☐ 2 Never	☐ 3 Rarely	☐ 4 Sometimes	☐ 5 Often	☐ 6 Always
When I was in pain I called out for someone to help me...	☐ 1 Had no Pain	☐ 2 Never	☐ 3 Rarely	☐ 4 Sometimes	☐ 5 Often	☐ 6 Always
When I was in pain I isolated myself from others…	☐ 1 Had no Pain	☐ 2 Never	☐ 3 Rarely	☐ 4 Sometimes	☐ 5 Often	☐ 6 Always
When I was in pain I thrashed…	☐ 1 Had no Pain	☐ 2 Never	☐ 3 Rarely	☐ 4 Sometimes	☐ 5 Often	☐ 6 Always

~ End of Questionnaire ~

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

The Brief Pain Inventory

Subject ID Number: _____

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

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

Brief Pain Inventory

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, toothaches). Have you had pain other than these everyday kinds of pain during the last week?

1. ☐ Yes 2. ☐ No

1a) Did you take pain medications in the last 7 days?

1. ☐ Yes 2. ☐ No

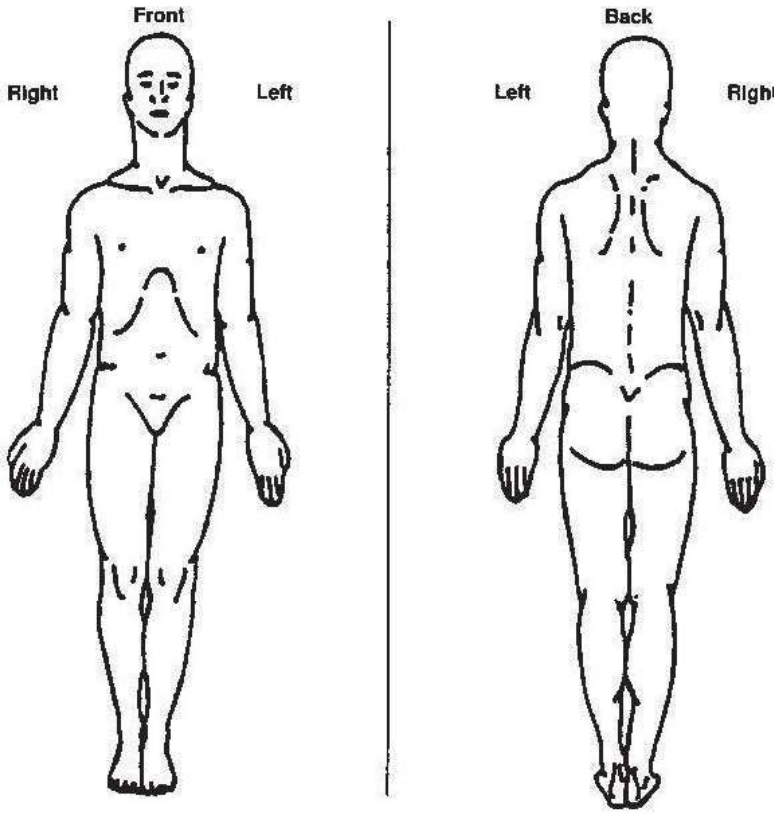
1b) I feel I have some form of pain now that requires medication each and every day.

1. ☐ Yes 2. ☐ No

IF YOUR ANSWERS TO 1, 1a, AND 1b WERE ALL NO, PLEASE STOP HERE AND GO TO THE NEXT QUESTIONNAIRE.

IF ANY OF YOUR ANSWERS TO 1, 1a, AND 1b WERE YES, PLEASE CONTINUE.

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its worst in the last week.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its least in the last week.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the average.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have right now.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

7) What kinds of things make your pain feel better (for example, heat, medicine, rest)?

_____

_____

8) What kinds of things make your pain worse (for example, walking, standing, lifting)?

_____

_____

9) In the last week, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Relief										Complete Relief

10) If you take pain medication, how many hours does it take before the pain returns?

1. ☐ Pain medication doesn't help at all
2. ☐ One hour
3. ☐ Two hours
4. ☐ Three hours
5. ☐ Four hours
6. ☐ Five to twelve hours
7. ☐ More than twelve hours
8. ☐ I do not take pain medication

11) Check the appropriate answer for each item.
I believe my pain is due to:

☐ Yes ☐ No 1. The effects of treatment (for example, medication, surgery, radiation, prosthetic device).

☐ Yes ☐ No 2. A medical condition (for example, arthritis).
Please describe condition: _____

12) For each of the following words, check Yes or No if that adjective applies to your pain.

1) Aching	☐ Yes	☐ No
2) Throbbing	☐ Yes	☐ No
3) Shooting	☐ Yes	☐ No
4) Stabbing	☐ Yes	☐ No
5) Gnawing	☐ Yes	☐ No
6) Sharp	☐ Yes	☐ No
7) Tender	☐ Yes	☐ No
8) Burning	☐ Yes	☐ No
9) Exhausting	☐ Yes	☐ No
10) Tiring	☐ Yes	☐ No
11) Penetrating	☐ Yes	☐ No
12) Nagging	☐ Yes	☐ No
13) Numb	☐ Yes	☐ No
14) Miserable	☐ Yes	☐ No
15) Unbearable	☐ Yes	☐ No

13) Circle the one number that describes how, during the past week, pain has interfered with your:

A. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking Ability

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal Work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

14) I prefer to take my pain medicine:

1. ☐ On a regular basis
2. ☐ Only when necessary
3. ☐ Do not take pain medicine (STOP-- GO TO NEXT QUESTIONNAIRE)

15) I take my pain medicine (in a 24 hour period):

1. ☐ Not every day
2. ☐ 1 to 2 times per day
3. ☐ 3 to 4 times per day
4. ☐ 5 to 6 times per day
5. ☐ More than 6 times per day

16) Do you feel you need a stronger type of pain medication?

1. ☐ Yes 2. ☐ No 3. ☐ Uncertain

17) Do you feel you need to take more of the pain medication than your doctor has prescribed?

1. ☐ Yes 2. ☐ No 3. ☐ Uncertain 4. ☐ N/A

18) Are you concerned that you use too much pain medication?

1. ☐ Yes 2. ☐ No 3. ☐ Uncertain

If Yes, why? _____

_____

19) Are you having problems with side effects from your pain medication?

1. ☐ Yes 2. ☐ No

Which side effects? _____

20) Do you feel you need to receive further information about your pain medication?

1. ☐ Yes 2. ☐ No

21) Other methods I use to relieve my pain include: (Please check all that apply)

Warm compresses ☐ Cold compresses ☐ Relaxation techniques ☐

Distraction ☐ Biofeedback ☐ Hypnosis ☐

Other ☐ Please specify _____

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

17a

Multi-Site Clinical Assessment of Chronic Fatigue Syndrome

PHQ-8 & GAD-7

Subject ID Number: _____

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

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

LIFETIME ANXIETY AND DEPRESSION

1. Has a doctor or other healthcare provider EVER told you that you had an anxiety disorder, including acute stress disorder, anxiety, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, phobia, posttraumatic stress disorder, or social anxiety disorder?

01 YES
02 NO
97 DON'T KNOW/ NOT SURE
99 REFUSED

2. Has a doctor or other healthcare provider EVER told you that you had a depressive disorder, including depression, dysthymia, or minor depression?

01 YES
02 NO
97 DON'T KNOW/ NOT SURE
99 REFUSED

PATIENT HEALTH QUESTIONNAIRE 8 (PHQ-8)

3. Over the last 2 weeks, how many days have you had little interest or pleasure in doing things?

__ __DAYS (RANGE=1-14)
88 NONE
97 DON'T KNOW/ NOT SURE
99 REFUSED

4. Over the last 2 weeks, how many days have you felt down, depressed or hopeless?

__ __DAYS (RANGE=1-14)
88 NONE
97 DON'T KNOW/ NOT SURE
99 REFUSED

5. Over the last 2 weeks, how many days have you had trouble falling asleep or staying asleep or sleeping too much?

__ __DAYS (RANGE=1-14)

88 NONE

97 DON'T KNOW/ NOT SURE

99 REFUSED

6. Over the last 2 weeks, how many days have you felt tired or had little energy?

__ __DAYS (RANGE=1-14)

88 NONE

97 DON'T KNOW/ NOT SURE

99 REFUSED

7. Over the last 2 weeks, how many days have you had a poor appetite or eaten too much?

__ __DAYS (RANGE=1-14)

88 NONE

97 DON'T KNOW/ NOT SURE

99 REFUSED

8. Over the last 2 weeks, how many days have you felt bad about yourself or that you were a failure or had let yourself or your family down?

__ __DAYS (RANGE=1-14)

88 NONE

97 DON'T KNOW/ NOT SURE

99 REFUSED

9. Over the last 2 weeks, how many days have you had trouble concentrating on things, such as reading the newspaper or watching the TV?

__ __DAYS (RANGE=1-14)

88 NONE

97 DON'T KNOW/ NOT SURE

99 REFUSED

10. Over the last 2 weeks, how many days have you moved or spoken so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?

__ __DAYS (RANGE=1-14)

88 NONE

97 DON'T KNOW/ NOT SURE

99 REFUSED

GENERALIZED ANXIETY DISORDER 7 (GAD-7)

Over the last two weeks, for how many days have you been bothered by the following problems…

11. Over the last 2 weeks, how many days have you been nervous, anxious, or on edge?

__ __DAYS (RANGE=1-14)
88 NONE
97 DON'T KNOW/ NOT SURE
99 REFUSED

12. Over the last 2 weeks, how many days have you not been able to stop or control worrying?

__ __DAYS (RANGE=1-14)
88 NONE
97 DON'T KNOW/ NOT SURE
99 REFUSED

13. Over the last 2 weeks, how many days have you worried too much about different things?

__ __DAYS (RANGE=1-14)
88 NONE
97 DON'T KNOW/ NOT SURE
99 REFUSED

14. Over the last 2 weeks, how many days have you had trouble relaxing?

__ __DAYS (RANGE=1-14)
88 NONE
97 DON'T KNOW/ NOT SURE
99 REFUSED

15. Over the last 2 weeks, how many days have you been so restless that it was hard to sit still?

__ __DAYS (RANGE=1-14)
88 NONE
97 DON'T KNOW/ NOT SURE
99 REFUSED

16. Over the last 2 weeks, how many days have you been easily annoyed or irritable?

__ __DAYS (RANGE=1-14)

88 NONE

97 DON'T KNOW/ NOT SURE

99 REFUSED

17. Over the last 2 weeks, how many days have you felt afraid as if something awful might happen?

__ __DAYS (RANGE=1-14)

88 NONE

97 DON'T KNOW/ NOT SURE

99 REFUSED

QUALITY OF LIFE – UNHEALTHY DAYS

18. 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

19. 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

~ End of the Questionnaire ~

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

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

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

17 c

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 ~

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Expiration date: 09/30/2023

18

Multi-Site Clinical Assessment of Chronic Fatigue Syndrome

Zung Self-Rating Depression Scale

Participant ID Number: _____

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

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

Zung Self-Rating Depression Scale

The following questions are about how you have felt recently. When answering the questions, please think how you felt the past seven days.

Please mark the appropriate box.

	None or a Little of the Time	Some of the Time	Good Part of the Time	Most or All of the Time
1. I feel down-hearted, blue, and sad.	❑ 1	❑ 2	❑ 3	❑ 4
2. Morning is when I feel the best.	❑ 1	❑ 2	❑ 3	❑ 4
3. I have crying spells or feel like it.	❑ 1	❑ 2	❑ 3	❑ 4
4. I have trouble sleeping through the night.	❑ 1	❑ 2	❑ 3	❑ 4
5. I eat as much as I used to.	❑ 1	❑ 2	❑ 3	❑ 4
6. I enjoy looking at, talking to, and being with attractive women/men.	❑ 1	❑ 2	❑ 3	❑ 4
7. I notice that I am losing weight.	❑ 1	❑ 2	❑ 3	❑ 4
8. I have trouble with constipation.	❑ 1	❑ 2	❑ 3	❑ 4
9. My heart beats faster than usual.	❑ 1	❑ 2	❑ 3	❑ 4
10. I get tired for no reason.	❑ 1	❑ 2	❑ 3	❑ 4
11. My mind is as clear as it used to be.	❑ 1	❑ 2	❑ 3	❑ 4
12. I find it easy to do the things I used to do.	❑ 1	❑ 2	❑ 3	❑ 4
13. I am restless and can't keep still.	❑ 1	❑ 2	❑ 3	❑ 4
14. I feel hopeful about the future.	❑ 1	❑ 2	❑ 3	❑ 4
15. I am more irritable than usual.	❑ 1	❑ 2	❑ 3	❑ 4
16. I find it easy to make decisions.	❑ 1	❑ 2	❑ 3	❑ 4

The following questions are about how you have felt recently. When answering the questions, please think how you felt the past seven days.

Please mark the appropriate box.

	None or a Little of the Time	Some of the Time	Good Part of the Time	Most or All of the Time
17. I feel that I am useful and needed.	❑ 1	❑ 2	❑ 3	❑ 4
18. My life is pretty full.	❑ 1	❑ 2	❑ 3	❑ 4
19. I feel that others would be better off if I were dead.	❑ 1	❑ 2	❑ 3	❑ 4
20. I still enjoy the things I used to do.	❑ 1	❑ 2	❑ 3	❑ 4

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19 Multi-Site Clinical Assessment of Chronic Fatigue Syndrome

Illness Impact Questionnaire

Subject ID Number: _____

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

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

Illness Impact Questionnaire

Please answer the following questions.

Directions: For each of the following 9 questions check the box that best indicates how much your illness made it difficult to perform each of the following activities during the past 7 days. If you did not perform a particular activity in the last 7 days, rate the difficulty for the last time you performed the activity. If you can't perform an activity, check the last box.

Brush or comb your hair	**No difficulty**	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult**
Walk continuously for 20 minutes	**No difficulty**	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult**
Prepare a homemade meal	**No difficulty**	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult**
Vacuum, scrub or sweep floors	**No difficulty**	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult**
Lift and carry a bag full of groceries	**No difficulty**	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult**
Climb one flight of stairs	**No difficulty**	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult**
Change bed sheets	**No difficulty**	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult**
Sit in a chair for 45 minutes	**No difficulty**	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult**
Go shopping for groceries	**No difficulty**	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult**

Directions: For each of the following 2 questions, check the box that best describes the overall impact of your illness over the last 7 days:

Illness prevented me from accomplishing goals for the week	**Never** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Always**
I was completely overwhelmed by my illness symptoms	**Never** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Always**

Directions: For each of the following 10 questions, select the box that best indicated your intensity of these common illness symptoms over the past 7 days	
Please rate your level of pain	**No pain** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Unbearable pain**
Please rate your level of energy	**Lots of energy** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **No energy**
Please rate your level of stiffness	**No stiffness** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Severe stiffness**
Please rate the quality of your sleep	**Awoke well rested** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Awoke very tired**
Please rate your level of depression	**No depression** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very depressed**
Please rate your level of memory problems	**Good memory** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very poor memory**
Please rate your level of anxiety	**Not anxious** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very anxious**
Please rate your level of tenderness to touch	**No tenderness** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very tender**
Please rate your level of balance problems	**No imbalance** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Severe imbalance**
Please rate your level of sensitivity to loud noises, bright lights, odors and cold	**No sensitivity** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Extreme sensitivity**

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Expiration date: 09/30/2023

Participant_ ID:

Saliva Collection Form

(To be filled out by the participant on the day of saliva collection)

IMPORTANT: Please read the saliva collection instructions before you complete this form.

Please answer the question below after completing saliva collection for each time point.

Date of Saliva Sample Collection: _____	
Is today a weekday or a weekend day?	❑ Weekday ❑ Weekend
Did you wake up on your own this morning?	❑ Yes ❑ No
	Time
At what time did you go to bed last evening?	a.m. / p.m.
At what time do you usually go to bed?	a.m. / p.m.
At what time did you collect saliva #1 (Awakening)?	a.m. / p.m.
At what time did you collect saliva #2 (+30 Minutes)?	a.m. / p.m.
At what time did you collect saliva #3 (+45 Minutes)?	a.m. / p.m.
At what time did you collect saliva #4 (+60 Minutes)?	a.m. / p.m.

Please indicate if you have any oral health problems/injuries: ❑ Yes ❑ No

Please indicate how you would rate your sleep last night with an X in one of the sections on the line:

I----------I----------I----------I----------I----------I----------I

Best Possible Sleep — Worst Possible Sleep

Saliva Collection Form: For Office Use only

(For use on the day of clinic appointment)

Participant_ ID:

Date of Saliva Collection: _____

Attention of clinic personnel: Please check the color of all four saliva collections
In the box below at time you receive saliva samples on the day of clinic appointment.

Office Use Only:

Color of saliva #1:	Color of saliva #2:	Color of saliva #3:	Color of saliva #4:
☐ 1 Clear	☐ 1 Clear	☐ 1 Clear	☐ 1 Clear
☐ 2 Brown	☐ 2 Brown	☐ 2 Brown	☐ 2 Brown
☐ 3 Red	☐ 3 Red	☐ 3 Red	☐ 3 Red
☐ 4 Pink	☐ 4 Pink	☐ 4 Pink	☐ 4 Pink
☐ 6 Other	☐ 6 Other	☐ 6 Other	☐ 6 Other
(Specify: _____)	(Specify: _____)	(Specify: _____)	(Specify: _____)

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Expiration date: 09/30/2023

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Multi-Site Clinical Assessment of Chronic Fatigue Syndrome

Orthostatic Grading Scale (OGS)

Subject ID Number: _____

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

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

OGS

Some patients tell us they feel worse when they are standing. For them, standing can worsen fatigue, pain or malaise or produce a feeling of light headedness or faintness. In the next questionnaire, we will ask you about these orthostatic symptoms. For each of the following 5 questions check the box that best indicates the frequency, severity, and impact of your orthostatic symptoms.

1. Frequency of orthostatic symptoms

	0	I *never* or rarely experience orthostatic symptoms when I stand up
	1	I *sometimes* experience orthostatic symptoms when I stand up
	2	I *often* experience orthostatic symptoms when I stand up
	3	I *usually* experience orthostatic symptoms when I stand up
	4	I *always* experience orthostatic symptoms when I stand up

2. Severity of orthostatic symptoms

	0	I *do not* experience orthostatic symptoms when I stand up
	1	I experience *mild* orthostatic symptoms when I stand up
	2	I experience *moderate* orthostatic symptoms when I stand up and *sometimes* have to sit back down for relief
	3	I experience *severe* orthostatic symptoms when I stand up and *frequently* have to sit back down for relief
	4	I experience *severe* orthostatic symptoms when I stand up and *regularly faint* if I do not sit back down

3. Conditions under which orthostatic symptoms occur

	0	I *never or rarely* experience orthostatic symptoms under any circumstances
	1	I *sometimes* experience orthostatic symptoms under certain conditions, such as prolonged standing, a meal, exertion (e.g., walking) or when exposed to heat (e.g. hot day, hot batch, hot shower)
	2	I *often* experience orthostatic symptoms under certain conditions, such as prolonged standing, a meal, exertion (e.g., walking), or when exposed to heat (e.g., hot day, hot bath, hot shower)
	3	I *usually* experience orthostatic symptoms under certain conditions, such as prolonged standing, a meal, exertion (e.g., walking), or when exposed to heat (e.g., hot day, hot bath, hot shower)
	4	I *always* experience orthostatic symptoms when I stand up; the specific conditions do not matter

4. Activities of daily living

	0	My orthostatic symptoms *do not interfere* with activities of daily living (e.g. work, chores, dressing, bathing)
	1	My orthostatic symptoms *mildly interfere* with activities of daily living (e.g. work, chores, dressing, bathing)
	2	My orthostatic symptoms *moderately interfere* with activities of daily living (e.g. work, chores, dressing, bathing)
	3	My orthostatic symptoms *severely interfere* with activities of daily living (e.g. work, chores, dressing, bathing)
	4	My orthostatic symptoms *severely interfere* with activities of daily living (e.g. work, chores, dressing, bathing). *I am bed or wheelchair bound because of my symptoms*

5. Standing time

	0	On most occasions, I can stand as long as necessary without experiencing orthostatic symptoms
	1	On most occasions, I can stand *more than 15 minutes* before experiencing orthostatic symptoms
	2	On most occasions, I can stand *5-14 minutes* before experiencing orthostatic symptoms
	3	On most occasions, I can stand *1-4 minutes* before experiencing orthostatic symptoms
	4	On most occasions, I can stand *less than 1 minute* before experiencing orthostatic symptoms

THIS IS THE END OF THE SURVEY

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Expiration date: 09/30/2023

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Multi-Site Clinical Assessment of Chronic Fatigue Syndrome

COMPosite Autonomic Symptom Score 31 (COMPASS-31)

Subject ID Number: _____

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

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

1. In the past year, have you ever felt faint, dizzy, “goofy”, or had difficulty thinking soon after standing up from a sitting or lying position?

    1 Yes

    2 No (if you marked No, please skip to question 5)

2. When standing up, how frequently do you get these feelings or symptoms?

    1 Rarely

    2 Occasionally

    3 Frequently

    4 Almost Always

3. How would you rate the severity of these feelings or symptoms?

    1 Mild

    2 Moderate

    3 Severe

4. In the past year, have these feelings or symptoms that you have experienced:

    1 Gotten much worse

    2 Gotten somewhat worse

    3 Stayed about the same

    4 Gotten somewhat better

    5 Gotten much better

    6 Completely gone

5. In the past year, have you ever noticed color changes in your skin, such as red, white, or purple?

    1 Yes

    2 No (if you marked No, please skip to question 8)

6. What parts of your body are affected by these color changes? (Check all that apply)

    1 Hands

    2 Feet

7. Are these changes in your skin color:

    1 Getting much worse
    2 Getting somewhat worse
    3 Staying about the same
    4 Getting somewhat better
    5 Getting much better
    6 Completely gone

8. In the past 5 years, what changes, if any, have occurred in your general body sweating?

    1 I sweat much more than I used to
    2 I sweat somewhat more than I used to
    3 I haven't noticed any changes in my sweating
    4 I sweat somewhat less than I used to
    5 I sweat much less than I used to

9. Do your eyes feel excessively dry?

    1 Yes
    2 No

10. Does your mouth feel excessively dry?

    1 Yes
    2 No

11. For the symptom of dry eyes or dry mouth that you have had for the longest period of time, is this symptom:

    1 I have not had any of these symptoms
    2 Getting much worse
    3 Getting somewhat worse
    4 Staying about the same
    5 Getting somewhat better
    6 Getting much better
    7 Completely gone

12. In the past year, have you noticed any changes in how quickly you get full when eating a meal?

    1 I get full a lot more quickly now than I used to

    2 I get full more quickly now than I used to

    3 I haven't noticed any change

    4 I get full less quickly now than I used to

    5 I get full a lot less quickly now than I used to

13. In the past year, have you felt excessively full or persistently full (bloated feeling) after a meal?

    1 Never

    2 Sometimes

    3 A lot of the time

14. In the past year, have you vomited after a meal?

    1 Never

    2 Sometimes

    3 A lot of the time

15. In the past year, have you had a cramping or colicky abdominal pain?

    1 Never

    2 Sometimes

    3 A lot of the time

16. In the past year, have you had any bouts of diarrhea?

    1 Yes

    2 No (if you marked No, please skip to question 20)

17. How frequently does this occur?

    1 Rarely

    2 Occasionally

    3 Frequently _____ times per month

    4 Constantly

18. How severe are these bouts of diarrhea?

1 Mild

2 Moderate

3 Severe

19. Are your bouts of diarrhea getting:

1 Much worse

2 Somewhat worse

3 Staying the same

4 Somewhat better

5 Much better

6 Completely gone

20. In the past year, have you been constipated?

1 Yes

2 No (if you marked No, please skip to question 24)

21. How frequently are you constipated?

1 Rarely

2 Occasionally

3 Frequently _____ times per month

4 Constantly

22. How severe are these episodes of constipation?

1 Mild

2 Moderate

3 Severe

23. Is your constipation getting:

1 Much worse

2 Somewhat worse

3 Staying the same

4 Somewhat better

5 Much better

6 Completely gone

24. In the past year, have you ever lost control of your bladder function?

1 Never

2 Occasionally

3 Frequently _____ times per month

4 Constantly

25. In the past year, have you had difficulty passing urine?

1 Never

2 Occasionally

3 Frequently _____ times per month

4 Constantly

26. In the past year, have you had trouble completely emptying your bladder?

1 Never

2 Occasionally

3 Frequently _____ times per month

4 Constantly

27. In the past year, without sunglasses or tinted glasses, has bright light bothered your eyes?

1 Never (if you marked Never, please skip to question 29)

2 Occasionally

3 Frequently

4 Constantly

28. How severe is this sensitivity to bright light?

1 Mild

2 Moderate

3 Severe

29. In the past year, have you had trouble focusing your eyes?

1 Never (if you marked Never, please skip to question 31)

2 Occasionally

3 Frequently

4 Constantly

30. How severe is this focusing problem?

1 Mild

2 Moderate

3 Severe

31. Is the most troublesome symptom with your eyes (i.e. sensitivity to bright light or trouble focusing) getting:

1 I have not had any of these symptoms

2 Much worse

3 Somewhat worse

4 Staying about the same

5 Somewhat better

6 Much better

7 Completely gone

THIS IS THE END OF THE SURVEY