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

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

Public reporting burden of this collection of information is estimated to average 24 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-XXXX

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

____

THIS IS THE END OF THE SURVEY