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 l	D Num	ıber: _				
Start Date	: Month		/ Year	& Time:	HH:MM	_am/pm
Complete Date:		/		_& Time: _.		_am/pm

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QUALITY	OF LIFE – UNHEALTHY	DAYS							
	inking about your physical hea			ness and injury,	for about how ma	ny			
	DAYS (RANGE=1 - 30)								
	88 NONE								
	97 DON'T KNOW/ NOT SU	URE							
	99 REFUSED								
	inking about your mental heal days during the past 30 days				ms with emotions	s, for			
	DAYS (RANGE=1-30)								
	88 NONE								
	97 DON'T KNOW/ NOT SU	URE							
	99 REFUSED								
CLINICAL	L GLOBAL IMPRESSION								
3. Overal	ll, how much has your health o	hangad sinaa	you first some to	the semiles?					
	Very much better	manged since	you first came to	ine service?					
a. b.	Much better								
c.	A little better								
d.	No change								
e.	A start								
f.	Much worse								
g.	Very much worse								
4. Please	list the top three treatments, neoming to this service and rate				impacted your ho	ealth			
Treatment	t/Medication/Management:	How h	nas your health c	hanged since st	arting this treati	nent?			
a.		Much Better	2 Somewhat better	About the Same	4 Somewhat Worse	Muc Wor			
b.		Much Better	2 Somewhat better	About the Same	4 Somewhat Worse	Muc Wor			

2 Somewhat

better

3 About the

Same

4 Somewhat

Worse

5 Much

Worse

Much

Better

c.