

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

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
52) Losing or gaining weight without trying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
53) No appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
54) Sweating hands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
55) Night sweats	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
56) Cold limbs (e.g. arms, legs, hands)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
57) Feeling chills or shivers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
58) Feeling hot or cold for no reason	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
59) Feeling like you have a high temperature	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
60) Feeling like you have a low temperature	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
61) Alcohol intolerance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
62) Sore throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
63) Tender/sore lymph nodes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
64) Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
65) Flu-like symptoms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
66) Some smells, foods, medications, or chemical make you feel sick	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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 is 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