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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

Public reporting burden of this collection of information is estimated to average 4 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

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. _____	<input type="checkbox"/> Much Better	<input type="checkbox"/> 2 Somewhat better	<input type="checkbox"/> 3 About the Same	<input type="checkbox"/> 4 Somewhat Worse	<input type="checkbox"/> 5 Much Worse
b. _____	<input type="checkbox"/> Much Better	<input type="checkbox"/> 2 Somewhat better	<input type="checkbox"/> 3 About the Same	<input type="checkbox"/> 4 Somewhat Worse	<input type="checkbox"/> 5 Much Worse
c. _____	<input type="checkbox"/> Much Better	<input type="checkbox"/> 2 Somewhat better	<input type="checkbox"/> 3 About the Same	<input type="checkbox"/> 4 Somewhat Worse	<input type="checkbox"/> 5 Much Worse

~ End of the Questionnaire ~