Form Approved
OMB Control No.: 0920-XXXX
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22

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