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

Appendix 16

Subject ID: _____

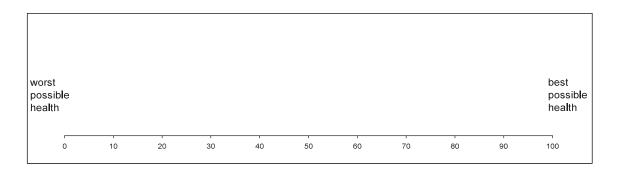
| Date (MM/DD/YY): | / | / | |
|------------------|---|---|--|

Visual Analogue Scale (VAS)

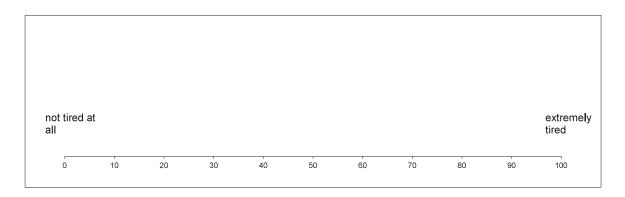
| DIRECTIONS: You are asked to place an "X" through these lin suppose you have not eaten since yesterday. Where would you not at all hungry | |
|---|--|
| | |
| You would probably put the "X" closer to the "extremely hunging not at all hungry | extremely hungry |
| | |
| NOW PLEASE COMPLETE THE FOLLOWING ITEMS. | |
| not at all hungry | extremely hungry |
| not at all tired | extremely tired |
| not at all sleepy | extremely sleepy |
| not at all drowsy | extremely drowsy |
| not at all fatigued | extremely fatigued |
| not at all worn out | extremely worn out |
| not at all energetic | extremely energetic |
| not at all active | extremely active |
| not at all vigorous | extremely vigorous |
| not at all efficient | extremely efficient |
| not at all lively | extremely lively |
| not at all bushed | totally bushed |
| not all exhausted | totally exhausted |
| keeping my eyes open is no effort at all | keeping my eyes open is a tremendous chore |
| moving my body is no effort at all | moving my body is a tremendous chore |
| concentrating is no effort at all | concentrating is a tremendous chore |
| carrying on a conversation is no effort at all | carrying on a conversation is a tremendous chore |
| I have absolutely no desire to close my eyes | I have a tremendous desire to close my eyes |
| I have absolutely no desire to lie down | I have a tremendous desire to lie down |

General state of health:

1. Think about your overall health today. What number between 0 and 100 best describes your health today? Please place an "X" on the scale below.



2. Think about how tired you feel today. What number between 0 and 100 best describes how tired you feel today? Please place an "X" on the scale below.



 $3. \quad \text{Circle the number of hours per day that your child spend} (s) \ in \ vertical \ or \ horizontal \ activity.$

Hours vertical of 24 hours (i.e., average time with feet on the floor---sitting, standing or walking)

<u>Hours horizontal of 24 hours</u> (i.e., average time with feet up--- resting in recliner, feet up, napping, sleeping in bed)

| Subject ID: | Date (MM/DD/YY):/ |
|-------------|-------------------|
| | |

Physical activity and play

| Current activity level | Number of hours |
|---|-----------------|
| How many <i>hours a week</i> does your child currently spend in physical activities/play? | |
| How many of the above hours are spent outdoors? | |
| What is his/her usual type of physical activity/play? Describe | |

Describe your child's physical activity and play **before** he/she became ill with Chronic Fatigue/ME

| Activity before he/she became ill with Chronic Fatigue/ME | Number of hours |
|--|-----------------|
| How many hours a week did your child spend in physical activities/play before this | |
| illness? | |
| How many of the above hours are spent outdoors? | |