INITIAL ASSESSMENT OF CFS PATIENT

Date: _____/_____/_____

CONTACT INFORMATION

Please answer a few questions about your background. Please fill in the answers to the questions below. All information will be kept strictly confidential.

1. Last Name: _____
2. First Name: _____
3. Current Address: _____

   Street Apt City State Zip
4. Telephone number: _____

   Other number: _____

   May we leave messages at this number? _____ yes _____ no
5. Date Of Birth: ___ ___ / ___ ___/ ___ ___ ___ ___ Social Sec # _____
6. E-Mail Address: _____
7. (A) Emergency Contact Name:_____

   Emergency Contact Number: _____

   (B) Emergency Contact Name:_____

   Emergency Contact Number: _____

   (C) Emergency Contact Name:_____

   Emergency Contact Number: _____
8. Primary Care Physician's name: _____

   Phone number: _____ Fax number: _____
9. If we can't find you through e-mail or phone, may we contact a member of your family to locate you? ____ **YES** ____ **NO**

   If yes which of the above named persons listed in question 7 should we contact? ____7A ____7B ____ 7C
10. What type of insurance do you have? _____

    ID# _____ Group # _____

    Do you know which lab they prefer/require? _____ Quest _____ Lab Corp

11. May we have your permission to:

____ Contact you about special events regarding Dr. Klimas or CFS or related topics?
____ Send you information about upcoming seminars and conferences?
____ Send you a newsletter from the Chronic Fatigue Center?
____ Contact you about research and/or foundation related fundraising events?
____ Store your blood sample in case we need to do additional studies?
____ Use stored blood for research purposes including genetic studies?
____ Contact you for any research studies related to CFS?

12. We are interested in learning more about CFS and its long term effects. Would you allow us to contact you annually and have you fill out forms similar to these?

____ YES ____ NO

_____ _____

Signature Date

Last name, First name: _____

MEDICAL HISTORY

Please answer the following questions about your medical history. All information will be kept strictly confidential. Mark XX by the appropriate answer.

Hospitalizations

1. Have you had any hospitalizations overnight or longer other than to have surgery?

____**YES** ____ **NO** ____ **NOT SURE** If yes, please give details.

a)_____

_____

b)_____

_____

c)_____

_____

d)_____

_____

e)_____

_____

2. Have you ever had surgery? ____**YES** ____ **NO** ____ **NOT SURE**

If yes, please list each operation and your age when the surgery was performed

A)_____

B)_____

C)_____

Allergy

3a. Are you allergic to any medicines?

Medicine:	**allergic?**		**Confirmed by doctor**	
_____	____YES	____ NO	____YES	____ NO
_____	____YES	____ NO	____YES	____ NO
_____	____YES	____ NO	____YES	____ NO
_____	____YES	____ NO	____YES	____ NO

3b. Are there any medicines that you do not tolerate?

_____

_____

_____

3c. Are you allergic to any foods:	**allergic?**		**Confirmed by doctor**	
_____	____YES	____ NO	____YES	____ NO
_____	____YES	____ NO	____YES	____ NO

4. Current Weight: _____ Height: _____

a) Has your weight increased or decreased by more than 10 pounds in the last year?

____ YES ____ NO

b) If you had specific weight changes, how many times did that happen? _____

c) By how much? _____ pounds

5. In the past year, how many colds, bouts of flu or upper respiratory infections have you had? (Indicate if continuous)

_____

6. Are you presently experiencing a cold or flu? ____ YES ____ NO ____ NOT SURE

7. Are you presently on any medications?

If yes, please list below any prescription, over the counter, or herbal medications you are currently taking.

Medication	Date of Start/Duration	Dosage	Clinical Reason
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____
6) _____	_____	_____	_____
7) _____	_____	_____	_____
8) _____	_____	_____	_____
9) _____	_____	_____	_____
10) _____	_____	_____	_____
11) _____	_____	_____	_____

Have you ever been told by a physician that you had any of the following conditions or illness?

CONDITION/ ILLNESS	Don't know	N0	YES	Year of diagnosis	Still present
Cardiovascular					□Yes □No
Angina					□Yes □No
Heart attack					□Yes □No
Heart condition that limits walking					□Yes □No
Heart failure					□Yes □No
Heart murmur					□Yes □No
Stroke					□Yes □No
Hypertension					□Yes □No
Low blood pressure					□Yes □No
Phlebitis					□Yes □No
Peripheral vascular disease					□Yes □No
Hemorrhoids					□Yes □No
Chest					
Asthma					□Yes □No
Chronic bronchitis					□Yes □No
Emphysema					□Yes □No
Pneumonia					□Yes □No
Tuberculosis					□Yes □No
Endocrine					
Adrenal insufficiency					□Yes □No
Overactive adrenal (Cushing's disease)					□Yes □No
Diabetes (1 or 2)					□Yes □No
Hypoglycemia					□Yes □No
Overactive thyroid					□Yes □No
Underactive thyroid					□Yes □No
Gastrointestinal					
Colitis					□Yes □No
Enteritis					□Yes □No
Gastritis					□Yes □No
Gallstones					□Yes □No
Crohn's disease					□Yes □No
Ulcerative colitis					□Yes □No
Irritable bowel Syndrome					□Yes □No
Malabsorption					□Yes □No
Celiac disease					□Yes □No
Pancreatitis					□Yes □No
Stomach or duodenal ulcer					□Yes □No
Liver Cirrhosis					□Yes □No
Chronic Hepatitis (A,B or C)					□Yes □No
Acute hepatitis (A,B or C)					□Yes □No
Liver damage due to alcohol					□Yes □No
Hematology					
Anemia requiring blood transfusion					□Yes □No
Malaria					□Yes □No

CONDITION/ ILLNESS	Don't know	N0	YES	Year of diagnosis	Still present
Hematology cont.					
Mononucleosis					□Yes □No
Sickle cell trait					□Yes □No
Sickle cell disease					□Yes □No
Neurological					
Meningitis					□Yes □No
Migraine					□Yes □No
Multiple sclerosis					□Yes □No
Neuralgia					□Yes □No
Peripheral neuropathy					□Yes □No
Seizure disorder					□Yes □No
Psychological					
Anorexia					□Yes □No
Bulimia					□Yes □No
Delusions					□Yes □No
Dementia					□Yes □No
Depression					□Yes □No
Drug abuse					□Yes □No
Alcohol abuse/dependency					□Yes □No
Bipolar disorder					□Yes □No
Rheumatologic					
Fibromyalgia					□Yes □No
Gout					□Yes □No
Systemic Lupus Erythematosus					□Yes □No
Lyme disease					□Yes □No
Osteoarthritis					□Yes □No
Psoriasis					□Yes □No
Rheumatic fever					□Yes □No
Rheumatoid arthritis					□Yes □No
Sjogren's syndrome					□Yes □No
TemporoMandibular Joint Syndrome					□Yes □No
Other autoimmune Specifiy:					□Yes □No
Tumors					
Malignant (include.lymphoma and leukemia) Specify					□Yes □No
Benign: Specify					□Yes □No
Urogenital					
Genital herpes					□Yes □No
Interstitial cystitis					□Yes □No
Kidney failure					□Yes □No
Kidney or bladder stone					□Yes □No
Urinary tract infection					□Yes □No

CONDITION/ ILLNESS	Don't know	N0	YES	Year of diagnosis	Still present
Female only					
Endometriosis					□Yes □No
Pelvic inflammatory disease					□Yes □No
Premenstrual syndrome					□Yes □No
Vaginal yeast infection					□Yes □No
Male only					
Epididymitis					□Yes □No
Prostatitis					□Yes □No
Varicocele					□Yes □No
Impotence					□Yes □No
Miscellaneous					
HIV infection					□Yes □No
Chronic fatigue syndrome					□Yes □No

CONDITION/ ILLNESS	Don't know	N0	YES	Year of diagnosis	Still present
Eczema					□Yes □No
Oral herpes (cold sores)					□Yes □No
Glaucoma					□Yes □No
Multiple chemical sensitivity					□Yes □No
Environmental hypersensitivity					□Yes □No
Sleep apnea					□Yes □No
Neurally mediated hypotension					□Yes □No
Postural orthostatic tachycardia syndrome					□Yes □No
Other:					

For women: Please mark accordingly

Have you had a hysterectomy?	□ Yes □ No □ Not sure
Have you had a tubal ligation? (had your tubes tied)	□ Yes □ No □ Not sure
Are you taking female hormones? (i.e. premarin, estrogen, estrogen patch, birth control pills)	□ Yes □ No □ Not sure
If using a birth control method, please specify which one	
Are you pregnant now	□ Yes □ No □ Not sure
Do you intend to become pregnant within the next 6 months?	□ Yes □ No □ Not sure
Have you been pregnant in the past?	□ Yes □ No □ Not sure
Are you currently breastfeeding?	□ Yes □ No
How old were you when you began menstruating?	_____years □ Not sure
Are you still menstruating?	
If yes:	
Last menstrual period began on date	___/ ___/ ____
1. Exact date 2. Approximate date	
How many days between menstrual periods	_____ days
If no,	
When did you stop menstruating?	___/ ____/ ____
Do you have any menopausal symptoms? (Please describe i.e hot flashes, night sweats, vaginal dryness)	
Are they mild, moderate or severe	

FAMILY MEDICAL HISTORY

Please answer the following questions about your family medical history. All information will be kept strictly confidential. Fill in the information or mark with X to indicate your answers.

RELATIVE	ALIVE	AGE	If deceased, cause of death
Mother	□ Yes □ No □ Don't know		
Father	□ Yes □ No □ Don't know		
Mother's mother	□ Yes □ No □ Don't know		
Mother's father	□ Yes □ No □ Don't know		
Father's mother	□ Yes □ No □ Don't know		
Father's father	□ Yes □ No □ Don't know		

SIBLINGS: (include siblings who have died, no half or stepbrothers or sisters)

Brothers: #	Ages:	If dead, age of death:
Sisters: #	Ages:	

ILLNESS	MOTHER	FATHER	SISTERS	BROTHERS	Mother's mother	Father's mother	Mother's father	Father's father
Heart attack								
Angina pectoris								
Heart disease								
Cancer (specify)								
Hypertension								
Low blood pressure								
Stroke								
Diabetes type 1								
Diabetes type 2								
Lung disease								
Chronic fatigue syndrome								
Hypothyroidism								
Major depressive disorder								
Autoimmune disease								
Fibromyalgia								
Any other serious illness. Specify								

Social History

Are you now:	□ Single □Married □Widowed □Divorced □Separated □Living with partner □Refuse to answer
If you have children	□ How many do you have: _____ □ How old are they: _____ years old
Highest grade or level of school you have completed	□ High school graduate □GED ore equivalent □ some college □ College graduate □ Graduate degree □ Professional degree □ Refuse to answer
We would like to know what you do. Check the one that best describes your current situation.	□ Working full-time □ Working part-time □ Temporarily laid off □ Sick leave □ Maternity leave □ Looking for work/ unemployed □ Retired □ Keeping house □ Disabled (permanently or temporarily) □ Student □ Other
If you stopped working, was it because of illness?	□ Yes □ No □ Other (specify) _____
Including yourself, how many people (related or not are living or staying at your home?	
Are you covered by health insurance or some other kind of health plan?	□ Yes, pleas name it _____ □ No
What kind of house do you currently live in?	□ Detached house □ Duplex or triplex □ Row house □ Mobile home or trailer □ Low rise apartment (1-3 floors) □ High rise apartment (>3 floors) □ Other
How old is the house/ building you live? (in years)	
Is there an enclosed garage attached?	□ Yes □No □Don't know
During the past 12 months, has there been water of dampness in your home from broken pipes, leaks, heavy rain or floods?	□ Yes □No □Don't know
Does your home frequently have a mildew odor or musty smell?	□ Yes □No □Don't know
Is air conditioning (refrigeration) used?	□ Yes □No □Don't know
In the last 12 months, did any dogs, cats or other small furry animals (like rabbit, guinea pig, hamster) live or spend time inside your home?	□ Yes □No □Don't know
What is the primary source of drinking water ?	□ Private well □Community supply □Bottled water □ Other
Have you EVER consumed unpasteurized dairy products (milk, cheese, goat cheese, etc)?	□ Yes □No □Don't know
Have you donated blood?	□ Yes □No □Don't know
If yes: have you donated blood or blood products in excess of 500ml within the past 56 days?	□ Yes □No □Don't know
How many times have you donated in the past 12 months?	
How many times have you donated in the past 10 years?	
How often do you have a drink containing alcohol?	□ Never □ Monthly or less □ 2-4 times a month □ 2-3 times per week □ 4 or more times a week
Which statement best describes your smoking status?	□ Never smoked □ Quit smoking □ Currently smoking
If you smoke, are you ready to stop smoking now?	□ No □ Yes, considering quitting □ Yes, attempting to quit now

Fatigue History

Did a physician or healthcare provider diagnose you with CFS?	□ Yes □ No
Do you have documentation of a CFS diagnosis from your physician or healthcare provider?	□ Yes □ No
How old were you when CFS first appeared?	
How old were you when you were first diagnosed with CFS by a healthcare provider?	
How would you describe the **ONSET** of your CFS □ Less than 24hours □ Over 48 hours □ A week □ A month □ Longer than a month □ Don't know	
Select the primary factor that you believe contributed to your **GETTING** CFS □ Infection □ Toxic exposure □ Vaccination □ Physical trauma □ Emotional trauma □ Other	
Select the primary factor that you believe contributed to your **STAYING ILL** with CFS □ Infection □ Toxic exposure □ Vaccination □ Physical trauma □ Emotional trauma □ Other	
Was your CFS linked to travel outside of the US?	□ Yes □ No
If yes, what country did you travel to?	
Since the **onset** of my condition, I consider it: □ Improved □ Worsened □ About the same	

Fatigue Characteristics

How frequently do you feel fatigued, tired or lack energy?	□ Less than once a week □ 1 to 4 times a week □ More than 4 times a week
When you feel well or greatly better, is it	□ for weeks or more at a time □ for days at a time □ Never
Is your fatigue made worse by physical exertion (effort or activity?	□ Yes □ No
Is your fatigue made worse by mental exertion (effort or activity?	□ Yes □ No
How long does it take the fatigue to begin after physical or mental exertion?	□ Immediately □ About one hour □ From one to three hours □ More than three hours □ More than 24 hours
How long does the fatigue last after physical or mental exertion?	□ One hour or less □ From one to three hours □ More than three hours, please specify # or hours ___
Does rest make your fatigue better?	□ Not at all □ A little bit □ A lot □ Don't know
Which of the following statements best describes our fatigue during the last month?	□ I am not able to work or do anything and I 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 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.
From 1 to 10, 10 being the worst How do you score your fatigue	
Today	
Usual fatigue level since your last visit	
Worst level of fatigue since last visit	

Symptom Questionnaire

Circle one number for <u>how often</u> and <u>how</u> <u>much</u> each symptom has bothered you <u>OVER THE PAST 6 MONTHS</u>. Go from left to right

Symptoms	How **<u>often</u>** have you had this symptom?					**How <u>much</u>** has this symptom bothered you?				
	None of the time 0	**A little of the time 1**	**About half of the time 2**	**Most of the time 3**	**All of the time 4**	**Symptom not present 0**	**Mild 1**	**Moderate 2**	**Severe 3**	**Very severe 4**
Fatigue/extreme tiredness	□	□	□	□	□	□	□	□	□	□
Dead, heavy feeling after starting to exercise	□	□	□	□	□	□	□	□	□	□
Next day soreness or fatigue after non-strenuous, everyday activities	□	□	□	□	□	□	□	□	□	□
Mentally tired after the slightest effort	□	□	□	□	□	□	□	□	□	□
Physically tired after minimum exercise	□	□	□	□	□	□	□	□	□	□
Physically drained or sick after mild activity	□	□	□	□	□	□	□	□	□	□
Feeling unrefreshed after waking up in the morning	□	□	□	□	□	□	□	□	□	□
Need to nap daily	□	□	□	□	□	□	□	□	□	□
Problems falling asleep	□	□	□	□	□	□	□	□	□	□
Problems staying asleep	□	□	□	□	□	□	□	□	□	□
Waking up early in the morning (e.g. 3am)	□	□	□	□	□	□	□	□	□	□
Sleep all day and stay awake all night	□	□	□	□	□	□	□	□	□	□
Muscle pain or aching	□	□	□	□	□	□	□	□	□	□
Pain/stiffness/tenderness in more than one joint without swelling or redness	□	□	□	□	□	□	□	□	□	□
Eye pain	□	□	□	□	□	□	□	□	□	□
Chest pain	□	□	□	□	□	□	□	□	□	□
Bloating	□	□	□	□	□	□	□	□	□	□
Abdomen/stomach pain	□	□	□	□	□	□	□	□	□	□
Headaches	□	□	□	□	□	□	□	□	□	□
Muscle twitches	□	□	□	□	□	□	□	□	□	□
Muscle weakness	□	□	□	□	□	□	□	□	□	□
Sensitivity to noise	□	□	□	□	□	□	□	□	□	□
Sensitivity to bright lights	□	□	□	□	□	□	□	□	□	□
Problems remembering things	□	□	□	□	□	□	□	□	□	□
Difficulty paying attention	□	□	□	□	□	□	□	□	□	□
Difficulty finding the right word to say or expressing thoughts	□	□	□	□	□	□	□	□	□	□
Difficulty understanding things	□	□	□	□	□	□	□	□	□	□

Symptoms	How **often** have you had this symptom?					**How much** has this symptom bothered you?				
	None of the time 0	A little of the time 1	About half of the time 2	Most of the time 3	All of the time 4	Symptom not present 0	Mild 1	Moderate 2	Severe 3	Very severe 4
Only can focus on one thing at a time	□	□	□	□	□	□	□	□	□	□
Unable to focus vision and attention	□	□	□	□	□	□	□	□	□	□
Loss of depth perception	□	□	□	□	□	□	□	□	□	□
Slowness of thought	□	□	□	□	□	□	□	□	□	□
Absent-mindedness or forgetfulness	□	□	□	□	□	□	□	□	□	□
Bladder problems	□	□	□	□	□	□	□	□	□	□
Irritable bowel problems	□	□	□	□	□	□	□	□	□	□
Nausea	□	□	□	□	□	□	□	□	□	□
Feeling unsteady on your feet, like you might fall	□	□	□	□	□	□	□	□	□	□
Shortness of breath or trouble catching your breath	□	□	□	□	□	□	□	□	□	□
Dizziness or fainting	□	□	□	□	□	□	□	□	□	□
Irregular heart beats	□	□	□	□	□	□	□	□	□	□
Losing or gaining weight without trying	□	□	□	□	□	□	□	□	□	□
No appetite	□	□	□	□	□	□	□	□	□	□
Sweating hands	□	□	□	□	□	□	□	□	□	□
Night sweats	□	□	□	□	□	□	□	□	□	□
Cold limbs (e.g. arms, legs, hands)	□	□	□	□	□	□	□	□	□	□
Feeling chills or shivers	□	□	□	□	□	□	□	□	□	□
Feeling hot or cold for no reason	□	□	□	□	□	□	□	□	□	□
Feeling like you have a high temperature	□	□	□	□	□	□	□	□	□	□
Feeling like you have a low temperature	□	□	□	□	□	□	□	□	□	□
Alcohol intolerance	□	□	□	□	□	□	□	□	□	□
Sore throat	□	□	□	□	□	□	□	□	□	□
Tender/sore lymph nodes	□	□	□	□	□	□	□	□	□	□
Fever	□	□	□	□	□	□	□	□	□	□
Flu-like symptoms	□	□	□	□	□	□	□	□	□	□
Some smells, foods, medications, or chemicals make you feel sick	□	□	□	□	□	□	□	□	□	□

MULTIDIMENSIONAL FATIGUE INVENTORY

Please rate your level of -agreement with each of the following statements:

1----------2----------3----------4----------5----------6----------7

Yes, That is true — **No, that is not true**

	1	2	3	4	5	6	7
I feel fit.							
Physically I feel only able to do a little.							
I feel very active.							
I feel like doing all sorts of nice things.							
I feel tired.							
I think I do a lot in a day.							
When I am doing something, I can keep my thoughts on it.							
Physically I can take on a lot.							
I dread having to do things.							
I think I do very little in a day.							
I can concentrate well.							
I am rested.							
It takes a lot of effort to concentrate on things.							
Physically I feel I am in a bad condition.							
I have a lot of plans.							
I tire easily.							
I get little done.							
I don't feel like doing anything.							
My thoughts easily wander.							
Physically I feel I am in an excellent condition.							

Karnofsky Performance Scale

Please mark the percentage that best describes your activity status

100% Totally well; no concerns about fatigue. You can think clearly and do several things at once. You can exercise to your maximum potential without any problems.

90% Energy good but you feel fatigued after hard exercise.

80% You feel well with respect to your energy but must monitor your energy through the day. Your thinking is good but not quite clear. Tasks are easy and you can still do multiple tasks at once. You are fatigued after moderate exercise. Full time work is possible for most.

70% Your overall energy is OK but everything you do is much more difficult and your energy is easily shifted. Your thought processes are much slower and more difficult and memory is poor. Exercise tolerance is poor and any strenuous exercise will make you feel unwell while light activity is tolerable. You can achieve a full day (8 hours) of tasks, but it requires a high degree of effort. You are too tired to do anything additional such as socializing. Full time work is possible only if you do not have to do any household tasks, errands or childcare. Part time work is possible for most.

60% You are able to complete 1/2 day of tasks and feel tired during it. Your thinking and memory are poor. You must rest at some point in the day. Even with rest, there is no part of the day in which you feel normal with respect to energy or can think clearly. Part time work is possible only if hours are flexible to coincide with your energy peaks and you do not have to do any household tasks, errands or childcare.

50% Your energy only allows you to do about 3 tasks per day (2-3 hours of activity). Your energy is easily drained. Thought processes are difficult. Your exercise tolerance is poor; walking up stairs is difficult.

40% You can only perform 2 light tasks per day. Physical exercise is not tolerable. Your thought processes are very slow and your memory is poor.

30% You can only perform one light task per day, any extra physical movement makes you feel unwell. You have difficulty reading and writing.

20% You are unable to perform any daily tasks; even going to the bathroom is tiring. The most physical exertion you can manage is to sit in a chair for short periods. Emotions are very unstable and fluctuate without warning.

10% You are in bed for most of the day and you have zero tolerance for anything extra. You are frequently too exhausted to even eat.

BRIEF PAIN INVENTORY

Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain, other than these everyday kinds of pain during the past 24 hours?	□Yes □ No
Would you consider your pain to be widespread and occurring in more than one spot on your body?	□Yes □ No

	With **0** being ***no pain*** and **10** being the ***worst pain*** you can imagine, please choose the number that best describes your level of pain in **the past 24 hours**.										
	0	1	2	3	4	5	6	7	8	9	10
Pain at its **worst**											
Pain at its **least**											
Pain on the **average**											
Pain you have **right now**											

Do you take any medications or receive any treatments for your pain? If so, write the treatments or medications you are taking or receiving for your pain in the box to the right.	
In the past 24 hours, how much relief have pain treatments or medications provided? 0% is no relief and 100% is complete relief	%

	With 0 being does not interfere and 10 being completely interferes, choose the one number that describes how, during										
	0	1	2	3	4	5	6	7	8	9	10
General activity											
Mood											
Walking ability											
Normal work											
Relations with other people											
Sleep											
Enjoyment of life											

GENERAL HEALTH QUESTIONNAIRE (SF-36)

In general, would you say your health is:				
□ Excellent	□ Very Good	□ Good	□ Fair	□ Poor

Compared to one year ago, how would you rate your health in general **now**?				
□ Much better	□ Somewhat better	□ Same	□ Somewhat worse	□ Much worse

The following items are about activities you might do during a typical day. Does your health now limit you in these activities and if so, how much? Check the appropriate box

	Yes limited a lot	**Yes limited a little**	**No not limited at all**
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	□	□	□
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	□	□	□
Lifting or carrying groceries	□	□	□
Climbing **several** flights of stairs	□	□	□
Climbing **one** flight of stairs	□	□	□
Bending, kneeling, or stooping	□	□	□
Walking **more** than a mile	□	□	□
Walking **several** blocks	□	□	□
Walking **one** block	□	□	□
Bathing or dressing yourself	□	□	□

*During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?*

	Yes	**No**
Cut down the **amount of time** you spent on work or other activities	□	□
Accomplished less than you would like	□	□
Were limited in the **kind** of work or other activities	□	□
Had **difficulty** performing the work or other activities (for example, it took extra effort)	□	□

*During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?*

	Yes	**No**
Cut down the **amount of time** you spent on work or other activities	□	□
Accomplished less than you would like	□	□
Didn't do work or other activities as **carefully** as usual	□	□

During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?				
□ Not at all	□ Slightly	□ Moderately	□ Quite a bit	□ Extremely

How much **bodily pain** have you had during the **past 4 weeks**?					
□ None	□ Very Mild	□ Mild	□ Moderate	□ Severe	□ Very Severe

During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?				
□ Not at all	□ A little bit	□ Moderately	□ Quite a bit	□ Extremely

*These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.*
*How much of the time during the **past 4 weeks:***

	All of the time	**Most of the time**	**Good bit of the time**	**Some of the time**	**A little bit of the time**	**None of the time**
Did you feel full of pep?	□	□	□	□	□	□
Have you been a very nervous person?	□	□	□	□	□	□
Have you felt so down in the dumps that nothing could cheer you up?	□	□	□	□	□	□
Have you felt calm and peaceful?	□	□	□	□	□	□
Did you have a lot of energy?	□	□	□	□	□	□
Have you felt downhearted and blue?	□	□	□	□	□	□
Did you feel worn out?	□	□	□	□	□	□
Have you been a happy person?	□	□	□	□	□	□
Did you feel tired?	□	□	□	□	□	□
During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?	□ All of the Time	□ Most of the time	□ Some of the time	□ A little of the time	□ None of the time	

How TRUE or FALSE is each of the following statements for you.

	Definitely true	**Mostly true**	**Don't know**	**Mostly false**	**Definitely false**
I seem to get sick a little easier than other people	□	□	□	□	□
I am as healthy as anybody I know	□	□	□	□	□
I expect my health to get worse	□	□	□	□	□
My health is excellent	□	□	□	□	□

HAD SCALE

Doctors are aware that emotions play an important part in most illnesses. If your doctor knows about these feelings he will be able to help you more.

This questionnaire is designed to help your doctor to know how you feel. Read each item and mark the reply which comes closest to how you have been feeling in the past week.

Don't take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought-out response.

I feel tense or "wound up":			**I feel as if I am slowed down**	
Most of the time			Nearly all the time	
A lot of the time			Very often	
Time to time, occasionally			Sometimes	
Not at all			Not at all	
I still enjoy the things I used to enjoy:			**I get a sort of frightened feeling like "butterflies" in the stomach**	
Definitely as much			Not at all	
Not quite so much			Occasionally	
Only a little			Quite often	
Hardly at all			Very often	
I get a sort of frightened feeling as if something awful is about to happen:			**I have lost interest in my appearance:**	
Very definitely & quite badly			Definitely	
Yes, but not too badly			I don't take so much care as I should	
A little, but it doesn't worry me			I may not take quite as much care	
Not at all			I take just as much care as ever	
I can laugh and see the funny side of things:			**I feel restless as if I have to be on the move:**	
As much as I always could			Very much indeed	
Not quite so much now			Quite a lot	
Definitely not so much now			Not very much	
Not at all			Not at all	
Worrying thoughts go through my mind:			**I look forward with enjoyment to things:**	
A great deal of the time			As much as ever I did	
A lot of the time			Rather less than I used to	
From time to time but not too often			Definitely less than I used to	
Only occasionally			Hardly at all	
I feel cheerful			**I get sudden feelings of panic:**	
Not at all			Very often indeed	
Not often			Quite often	
Sometimes			Not very often	
Most of the time			Not at all	
I can sit at ease and feel relaxed			**I enjoy a good book or radio or TV program:**	
Definitely			Often	
Usually			Sometimes	
Not often			Not often	
Not at all			Very seldom	

SLEEP ASSESSMENT QUESTIONNAIRE

PLEASE ANSWER EACH QUESTION BY CHECKING THE ONE ANSWER THAT FITS BEST

Over the past month, how often have you experienced the following……..

	Never	Rarely	Some times	Often	Always	Don't Know
1. Difficulty falling asleep?						
2. Sleeping for less than 5 hours?						
3. Sleeping more than 9 hours?						
4. Repeated awakenings during your sleep?						
5. Loud snoring?						
6. Interruptions to your breathing during sleep?						
7. Restlessness during your sleep (e.g. move your legs or kick)?						
8. Nightmares or waking up frightened or crying out loud?						
9. Waking up before you want to (i.e., getting less sleep than you need)?						
10. Waking up NOT feeling refreshed or thoroughly rested?						
11. Waking up with aches or pains or stiffness?						
12. Falling asleep while sitting (e.g., reading, watching t.v.)?						
13. Falling asleep while doing something (e.g., driving, talking to people)?						
14. Working shifts?						
15. Working night shifts?						
16. Irregular bed time and/or wakeup time during work or weekdays?						
17. Taking medication for sleep or nervousness?						