DePaul University Fatigue Questionnaire

1a) Are you currently experiencing any problems with fatigue or tiredness? ❑ No ❑ Yes

1b) If you replied "**Yes**" to **1a**: When did the fatigue begin? _____

1c) If you replied "**Yes**" to **1a**: What do you think the cause of your fatigue is? _____

_____

_____

2) When your problem with fatigue began, did it develop (check one): ❑ Rapidly - within 24 hours

❑ Over 1 week ❑ Over 1 month ❑ Over 2-6 months

❑ Over 7-12 months ❑ Over 1-2 years ❑ Longer than 2 years

❑ had problems with fatigue since childhood or adolescence ❑ N/A – Not having problem with fatigue

3) In the past month, how many hours a week have you spent doing: household related activities? _____

social-related activities? _____

work-related activities? _____

4a) In the past 6 months, have you had to reduce the number of hours you previously spent on occupational, social or family activities because of your health or problems with fatigue? ❑ No ❑ Yes

4b) If you replied **"Yes"** to **4a**: Which activities and by how many hours per week have you cut back?

❑ Occupational: decreased by_____hrs/week

❑ Social: decreased by_____hrs/week

❑ Family: decreased by_____hrs/week

4c) If you replied **"Yes"** to **4b**: How many hours did you used to spend on:

Occupational activities? _____

Social activities? _____

Family activities? _____

5a) If you rest, does your fatigue go away entirely, partially, or does rest have no effect on your fatigue (check one): ❑ Entirely ❑ Partially ❑ No effect

5b) If you replied "**Entirely**" or "**Partially**" to **5a**:

How long do you have to rest for your fatigue entirely or partially goes away? _____

Will your fatigue return if you stop resting and start doing something? ❑ No ❑ Yes

6) Do you restrict your activity levels to avoid experiencing severe fatigue? ❑ No ❑ Yes

7) Does physical activity make you feel: ❑ Worse ❑ Better ❑ Has no effect

8a) In the past 6 months, how often have you experienced a persistent or recurrent problem with post-exertional malaise? By post-exertional malaise I mean do you begin to feel worse after engaging in activities that require either physical or mental exertion?

❑ Never ❑ Seldom ❑ Often or Usually ❑ Always

8b) If you replied "**Often or Usually**" or "**Always**" to **8a**: How long does the post-exertional malaise for?

(check one): ❑ less than 1 hour ❑ 1-3 Hrs ❑ 4-10 Hrs ❑ 11-13 Hrs
❑ more than 13 Hrs _____ (specify how long) ❑ More than 24 Hrs

8c) If you replied "**Never**" or "**Seldom**" to **8a**: What about if you exercise – do you experience increased fatigue or a worsening of your symptoms after engaging in exercise? ❑ No ❑ Yes

8d) If you replied "**No**" to **8c**: Is that because you are not exercising or does exertion just not effect your symptoms, or does it even make you feel better?

❑ Not exercising ❑ No effect ❑ Feel better

8e) If you replied "**Not Exercising**" to **8d**: Why aren't you exercising? ❑ Not interested ❑ No time
❑ Would like to but cannot because of fatigue ❑ Cannot because exercise makes symptoms worse

9) For the **past day** (past 24 hrs), please rate the amount of perceived energy you have had using a scale from 0 to 100 where 0 = no energy and 100 = your pre-illness energy level _____

10) For the **past day** (past 24 hrs), please rate the amount of energy you have expended (used) using a scale from 0 to 100 where 0 = no energy and 100 = your pre-illness energy expended _____

11) For the **past day** (past 24 hrs), please rate the amount of fatigue you have had using a scale from 0 to 100 where 0 = no fatigue and 100 = severe fatigue _____

12) For the **past week**, please rate the amount of perceived energy you have had using a scale from 0 to 100 where 0 = no energy and 100 = your pre-illness energy level _____

13) For the **past week,** please rate the amount of energy you have expended (used) using a scale from 0 to 100 where 0 = no energy and 100 = your pre-illness energy expended _____

14) For the **past week**, please rate the amount of fatigue you have had using a scale from 0 to 100 where 0 = no fatigue and 100 = severe fatigue _____

15) How would you describe the course of your illness / health problems (check one):

❑ Constantly getting worse ❑ Constantly improving ❑ Persisting (no change)
❑ Relapsing & remitting (having "good" periods with no symptoms & "bad" periods)
❑ Fluctuating (symptoms periodically wax & wane, but never disappear completely)

16a) Do you have any known diagnosed medical conditions?_____

_____

_____

16b) For which these conditions are you currently receiving treatment or taking medication?_____

_____

_____

17a) Are you currently taking any medications? ❑ No ❑ Yes

17b) If you replied "**Yes**" to **17a:** What medications are you taking? _____

_____

_____

18) How often do you drink alcohol: ❑ Never ❑ Rarely ❑ Weekly ❑ Daily

19) When you drink, how much do you typically drink? _____

20a) Are you currently using recreational drugs? ❑ No ❑ Yes

20b) If you replied "**Yes**" to **20a:** Which drugs and how often and much do you use? _____

_____

_____

21a) Have you ever used recreational drugs in the past? ❑ No ❑ Yes

21b) If you replied "**Yes**" to **21a:** Which drugs and how often and much do you use? _____

_____

_____

22a) Have you ever been diagnosed or treated for an eating disorder? ❑ No ❑ Yes:

22b) If you replied "**Yes**" to **22a:** When did that problem begin? _____.

Do you still have an eating disorders? ❑ Yes ❑ No: When did the problem stop? _____.

For the symptoms below, please indicate in the first column by placing a check (✔) those symptoms that have persisted or reoccurred during 6 or more consecutive months of the fatigue illness or during your health problems.

In the next column please check (✔) those symptoms that began before you started having a persistent or recurring problem with fatigue.

In the third column please indicate how often you have experienced any of the following symptoms **in the past 6 months** using these response categories: Never, seldom (about once a month or less), often or usually (occurs monthly), or always.

In the last column please rate the severity of each symptom you have experienced **over the past 6 months** using a scale of 0 to 100 where 0 = no problem and 100 = the most severe problem possible.

	Symptom Has been Present for 6 Months or longer	Symptom Began before Fatigue or health Problems started	Frequency (Never, Seldom, Often or Usually, or Always)	Symptom Severity Rating 0 to 100
23) Fatigue	_____	_____	_____	_____
24) Sore Throat	_____	_____	_____	_____
25) Tender/Sore Lymph Nodes	_____	_____	_____	_____
26) Muscle Pain (i.e., sensations of pain or aching in your muscles. This **does not** include weakness or pain in other areas such as joints)	_____	_____	_____	_____
27) Pain in Multiple Joints without Swelling or Redness	_____	_____	_____	_____
28) Impaired Memory & concentration	_____	_____	_____	_____
29) Nausea	_____	_____	_____	_____
30) Fever & Chills	_____	_____	_____	_____
31) Muscle Weakness	_____	_____	_____	_____
32) Sensitivity to Alcohol	_____	_____	_____	_____
33) Unrefreshing Sleep, that is waking up feeling tired	_____	_____	_____	_____
34) Post-exertional malaise, feeling worse after doing activities that require either physical or mental exertion	_____	_____	_____	_____
35) Headaches	_____	_____	_____	_____

****IF EXPERIENCING HEADACHES**:

36) Are these headaches you are experiencing more frequent, more severe, or in a different location than the headaches you experienced in the past before you began have problems with fatigue and your health? (**check all that apply**)
❑ More frequent ❑ More severe ❑ Different location

OTHER SYMPTOMS

	Symptom Has been Present for 6 Months or longer	Symptom Began before Illness or health Problems started	Frequency (Never, Seldom, Often or Usually, or Always)	Symptom Severity Rating 0 to 100
Physical Complaints				
Racing heart	_____	_____	_____	_____
Chest pain	_____	_____	_____	_____
Shortness of breath	_____	_____	_____	_____
Upset stomach	_____	_____	_____	_____
Abdomen pain	_____	_____	_____	_____
Weight change	_____	_____	_____	_____
Poor Appetite	_____	_____	_____	_____
Dizziness	_____	_____	_____	_____
Ringing in the ears	_____	_____	_____	_____
Sweating hands	_____	_____	_____	_____
Night sweats	_____	_____	_____	_____
Tense muscles	_____	_____	_____	_____
Chilled or shivery	_____	_____	_____	_____
Hot or cold spells	_____	_____	_____	_____
Feeling like you have a temperature	_____	_____	_____	_____
Fevers	_____	_____	_____	_____
Temperature lower than normal	_____	_____	_____	_____
Tingling feeling	_____	_____	_____	_____
Paralysis	_____	_____	_____	_____
Blurred vision	_____	_____	_____	_____
Abnormal sensitivity to light	_____	_____	_____	_____
Blind spots	_____	_____	_____	_____
Eye pain	_____	_____	_____	_____
Rash	_____	_____	_____	_____
Allergies	_____	_____	_____	_____
Chemical sensitivity	_____	_____	_____	_____
Muscle weakness	_____	_____	_____	_____
Feel unsteady on feet	_____	_____	_____	_____

OTHER SYMPTOMS (continued)

	Symptom Has been Present for 6 Months or longer	Symptom Began before Illness or health Problems started	Frequency (Never, Seldom, Often or Usually, or Always)	Symptom Severity Rating 0 to 100
Need to nap during each day	_____	_____	_____	_____
Difficulty falling asleep	_____	_____	_____	_____
Difficulty staying asleep	_____	_____	_____	_____
Waking up early in the morning (e.g., 3 AM)	_____	_____	_____	_____
Difficulty staying asleep	_____	_____	_____	_____
Other_____	_____	_____	_____	_____
Other Cognitive Difficulties				
Slowness of thought	_____	_____	_____	_____
Absent-mindedness	_____	_____	_____	_____
Confusion/disorientation	_____	_____	_____	_____
Difficulty reasoning things out	_____	_____	_____	_____
Forgetting what you are trying to say	_____	_____	_____	_____
Difficulty finding the right word	_____	_____	_____	_____
Difficulty following things	_____	_____	_____	_____
Difficulty comprehending Information	_____	_____	_____	_____
Need to have to focus on one thing at a time	_____	_____	_____	_____
Frequently lose train of thought	_____	_____	_____	_____
Trouble expressing thoughts	_____	_____	_____	_____
Difficulty retaining information	_____	_____	_____	_____
Difficulty recalling information	_____	_____	_____	_____
Frequently get words or numbers in the wrong order	_____	_____	_____	_____
Slow to react	_____	_____	_____	_____
Poor hand to eye coordination	_____	_____	_____	_____
New trouble with math	_____	_____	_____	_____
Concern with driving	_____	_____	_____	_____
Other_____	_____	_____	_____	_____

OTHER SYMPTOMS (continued)

	Symptom Has been Present for 6 Months or longer	Symptom Began before Illness or health Problems started	Frequency (Never, Seldom, Often or Usually, or Always)	Symptom Severity Rating 0 to 100
Mood Difficulties				
Anxiety/tension	_____	_____	_____	_____
Easily irritated	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Mood swings	_____	_____	_____	_____
Other_____	_____	_____	_____	_____