

## 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<br>Has been<br>Present for 6<br>Months or longer | Symptom<br>Began before<br>Fatigue or health<br>Problems started | Frequency ( <u>Never</u> ,<br><u>Seldom</u> ,<br><u>Often or Usually</u> ,<br>or <u>Always</u> ) | Symptom<br>Severity<br>Rating<br>0 to 100 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------|
| 23) Fatigue                                                                                                                                                          | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| 24) Sore Throat                                                                                                                                                      | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| 25) Tender/Sore Lymph Nodes                                                                                                                                          | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| 26) Muscle Pain (i.e., sensations<br>of pain or aching in your<br>muscles. This <b><u>does not</u></b><br>include weakness or pain<br>in other areas such as joints) | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| 27) Pain in Multiple Joints<br>without Swelling or Redness                                                                                                           | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| 28) Impaired Memory &<br>concentration                                                                                                                               | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| 29) Nausea                                                                                                                                                           | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| 30) Fever & Chills                                                                                                                                                   | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| 31) Muscle Weakness                                                                                                                                                  | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| 32) Sensitivity to Alcohol                                                                                                                                           | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| 33) Unrefreshing Sleep, that is<br>waking up feeling tired                                                                                                           | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| 34) Post-exertional malaise,<br>feeling worse after doing<br>activities that require either<br>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<br>Has been<br>Present for 6<br>Months or longer | Symptom<br>Began before<br>Illness or health<br>Problems started | Frequency ( <u>Never</u> ,<br><u>Seldom</u> ,<br><u>Often or Usually</u> ,<br>or <u>Always</u> ) | Symptom<br>Severity<br>Rating<br>0 to 100 |
|----------------------------------------|----------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------|
| <u>Physical Complaints</u>             |                                                          |                                                                  |                                                                                                  |                                           |
| 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<br>temperature | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Fevers                                 | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Temperature lower<br>than normal       | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Tingling feeling                       | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Paralysis                              | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Blurred vision                         | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Abnormal sensitivity to<br>light       | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Blind spots                            | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Eye pain                               | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Rash                                   | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Allergies                              | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Chemical sensitivity                   | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Muscle weakness                        | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Feel unsteady on feet                  | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |

## OTHER SYMPTOMS (continued)

|                                                       | Symptom<br>Has been<br>Present for 6<br>Months or longer | Symptom<br>Began before<br>Illness or health<br>Problems started | Frequency ( <u>Never</u> ,<br><u>Seldom</u> ,<br><u>Often or Usually</u> ,<br>or <u>Always</u> ) | Symptom<br>Severity<br>Rating<br>0 to 100 |
|-------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------|
| Need to nap during each day                           | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Difficulty falling asleep                             | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Difficulty staying asleep                             | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Waking up early in the<br>morning (e.g., 3 AM)        | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Difficulty staying asleep                             | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Other_____                                            | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| <u>Other Cognitive Difficulties</u>                   |                                                          |                                                                  |                                                                                                  |                                           |
| Slowness of thought                                   | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Absent-mindedness                                     | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Confusion/disorientation                              | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Difficulty reasoning<br>things out                    | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Forgetting what you are<br>trying to say              | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Difficulty finding the<br>right word                  | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Difficulty following things                           | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Difficulty comprehending<br>Information               | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Need to have to focus on<br>one thing at a time       | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Frequently lose train of thought                      | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Trouble expressing thoughts                           | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Difficulty retaining information                      | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Difficulty recalling information                      | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Frequently get words or<br>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<br>Has been<br>Present for 6<br>Months or longer | Symptom<br>Began before<br>Illness or health<br>Problems started | Frequency ( <u>Never</u> ,<br><u>Seldom</u> ,<br><u>Often or Usually</u> ,<br>or <u>Always</u> ) | Symptom<br>Severity<br>Rating<br>0 to 100 |
|--------------------------|----------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------|
| <u>Mood Difficulties</u> |                                                          |                                                                  |                                                                                                  |                                           |
| Anxiety/tension          | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Easily irritated         | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Depression               | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Mood swings              | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |
| Other _____              | _____                                                    | _____                                                            | _____                                                                                            | _____                                     |

