

FIBROMYALGIA/CHRONIC FATIGUE SYNDROME QUESTIONNAIRE

Patient Name _____ Age _____

Birth Date _____ Single _____ Married _____ Widowed _____ Divorced _____

Number of Children & Ages _____

Occupation _____

Check any of the following that apply to you:

Predisposing Factors

- 1 _____ I have had one or more stressful events that have affected my health
- 2 _____ I have continuous stressors that affect my health
- 3 _____ I developed FM/CFS following an accident or injury
- 4 _____ I developed FM/CFS following a stressful life event
- 5 _____ I push myself to exhaustion
- 6 _____ I have little time or energy to care for myself (eats regularly, rest, etc.)
- 7 _____ I have a very stressful job
- 8 _____ I do not enjoy my line of work
- 9 _____ I have little or no control over the stress in m life
- 10 _____ I currently have relationship or family difficulties
- 11 _____ My state of health is a major stress factor
- 12 _____ I do not have a good support system of friends or family
- 13 _____ I have a history of physical, emotional or sexual abuse
- 14 _____ I do not sleep well
- 15 _____ I have or have had an eating disorder
- 16 _____ I eat mostly processed food/fast food diet
- 17 _____ I do not exercise regularly

Contributing Factors

- 1 _____ I Antacid use --- How long? _____
- 2 _____ I take or have taken Prilosec, Precacid, Nexium or another acid-stopping medication
How long? _____
- 3 _____ Multiple rounds of antibiotic use
- 4 _____ Long term steroid use
- 5 _____ I drink more than 2 glasses of an alcoholic beverage per day
- 6 _____ Irritable bowel syndrome
- 7 _____ Gall bladder removed _____ When? _____
- 8 _____ Crohn's disease
- 9 _____ Allergies --- To what? _____
- 10 _____ Parasites
- 11 _____ Candida
- 12 _____ Low blood pressure

FM/CFS QUESTIONNAIRE, cont'd.

- 13 _____ Skin condition --- What? _____
- 14 _____ I tend to be anemic
- 15 _____ I have been diagnosed with a sleep disorder --- What? _____
- 16 _____ Took or take oral or injected contraceptives
- a. What? _____
- b. When? _____ How long? _____
- 17 _____ I am menopausal or perimenopausal
- 18 _____ Took or take conventional HRT
- a. What? _____
- b. When? _____ How long? _____
- 19 _____ Hysterectomy---Ovaries removed? _____
- 20 _____ Chemotherapy and/or radiation?
- a. For what? _____
- b. When? _____

How long have you felt like this?

I have not felt well since _____ (date)
What happened at that time? (Describe any event, situation, etc.)

SIGNS & SYMPTOMS QUESTIONS

Rate the following from 0 to 5, (with 0 being no problem, and 5 being a severe problem)

- 1 _____ Fatigue
- 2 _____ Need to rest a lot more than I used to
- 3 _____ Difficulty getting to sleep
- 4 _____ Difficulty staying asleep
- 5 _____ Non-restful sleep
- 6 _____ Slow starter
- _____ Total for this page

FM/CFS QUESTIONNAIRE, cont'd.

- 7 Less productive with work
- 8 Difficulty handling pressure or stress
- 9 Get sleepy during the day
- 10 Less energy for or interest in things I enjoy
- 11 Poor stamina
- 12 Trouble focusing on work or projects
- 13 Little or no energy for exercising
- 14 No energy left over for anything that I don't have to do
- 15 Do not feel well
- 16 Muscle pains/aches --- Where? _____
- 17 Muscle spasm --- Where? _____
- 18 Joint pains --- Where? _____
- 19 Numbness or tingling --- Where? _____
- 20 Burning pains --- Where? _____
- 21 Other pains --- Where? _____
- 22 Stiffness
- 23 Poor muscle strength or tone
- 24 Feel weak
- 25 Flu-like feelings
- 26 Exercise intolerance (excessive pain after exercise)
- 27 Prolonged fatigue after exertion
- 28 Increased pain sensitivity
- 29 Increased sensitivity to noise, light, touch
- 30 I have trouble slowing down or relaxing
- 31 Headaches or migraines
- 32 Neck or shoulder tension
- 33 Cold hands or feet
- 34 Tend to be cold all over
- 35 Indigestion
- 36 Bloating
- 37 Belching
- 38 Gas
- 39 Nausea
- 40 Acid reflux
- 41 Loss of taste for meat
- 42 Burning when stomach is empty
- 43 Gall bladder problems (removed)
- 44 Diarrhea
- 45 Constipation
- 46 Swollen lymph glands
- 47 Sore throat
- 48 Chronic sinus congestion
- 49 Chronic or recurring infections

_____ Total for this page

(continued on next page)

FM/CFS QUESTIONNAIRE, cont'd.

- 50 Skin rashes
 - 51 Itching skin
 - 52 Dry eyes, nose or mouth
 - 53 Vision changes, becoming blurred or weaker
 - 54 Difficulty concentrating
 - 55 Poor memory
 - 56 Brain fog
 - 57 Confusion
 - 58 anxiety
 - 59 I feel constantly stressed
 - 60 Become agitated or irritated or lose patience more easily than I used to
 - 61 I am more moody than I used to be
 - 62 Panic attacks
 - 63 Low mood
 - 64 Depression
 - 65 Low self esteem
 - 66 Feelings of worthlessness
 - 67 Feelings of despair
 - 68 Loss of interest in daily activities
 - 69 Loss of or less enjoyment in living
 - 70 Withdrawn from social activities
 - 71 Low self-confidence
 - 72 I have trouble making decisions
 - 73 Hypoglycemia (low blood sugar)
 - 74 Sweet, chocolate or carbohydrate cravings
 - 75 Salt cravings
 - 76 Alcohol cravings
 - 77 Shakiness relieved by eating
 - 78 Get shaky, irritable or headache if a meal is skipped
 - 79 Tired after meals
 - 80 I eat a low-fat diet
 - 81 I restrict my salt intake. Why? _____
 - 82 I eat a lot of dairy
 - 83 I eat a lot of sugar
 - 84 I drink a lot of sodas
 - 85 Dizziness
 - 86 Light-headed upon arising
 - 87 Brown spots appearing on skin
 - 88 Unexplained fears or worries
 - 89 Excessive fears or worries
 - 90 Snoring
 - 91 Restless legs
- Total for this page

FM/CFS QUESTIONNAIRE, cont'd.

- 92 _____ Arms and/or legs jerk when in bed
 - 93 _____ Grind teeth at night
 - 94 _____ Urinary frequency
 - 95 _____ Night-time urinary frequency
 - 96 _____ Urinary tract infection
 - 97 _____ Vaginal dryness, irritation or infections
 - 98 _____ Hot flashes
 - 99 _____ Night sweats
 - 100 _____ PMS
 - 101 _____ Infertility
 - 102 _____ Heavy bleeding, clotting or cramping with periods
 - 103 _____ Irregular periods
 - 104 _____ Decreased libido
 - 105 _____ Erectile Dysfunction
 - 106 _____ Weight gain, especially around the middle
 - 107 _____ Unexplained weight loss
 - 108 _____ Bruise easily
 - 109 _____ Heavy legs/aching legs
 - 110 _____ Edema (water retention)
 - 111 _____ Become short of breath easily
 - 112 _____ Chest pain
 - 113 _____ Palpitations
 - 114 _____ Loneliness
 - 115 _____ Most people don't understand my condition
 - 116 _____ Little or no support from friends or family
- _____ Total for this page

GRAND TOTAL _____ **RANGE:** **Moderate** **Severe** **Extreme**

HISTORY

List any conditions that you have been diagnosed with, and the dates.

| | |
|--|------|
| | Date |
| | Date |
| | Date |
| | Date |
| | Date |
| | Date |
| | Date |
| | Date |

(continued on next page)

List any surgeries or traumas you've had, and the dates.

| | |
|-------|------------|
| _____ | Date _____ |
| _____ | Date _____ |
| _____ | Date _____ |
| _____ | Date _____ |
| _____ | Date _____ |
| _____ | Date _____ |
| _____ | Date _____ |
| _____ | Date _____ |
| _____ | Date _____ |
| _____ | Date _____ |
| _____ | Date _____ |

List any medications you are taking.

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

List nutritional supplements, vitamins and herbs you are taking.

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Describe anything you feel is contributing to your condition.

Add anything else you have to say.

EVALUATION AND SCORING

PREDISPOSING FACTORS – no score is used here. These factors are for consideration of what has led to FM/CFS, and what may need to change.

CONTRIBUTING FACTORS – No score is used here. This information is to help discover what health care factors may have contributed to FM/CFS.

SIGNS AND SYMPTOMS QUESTIONS – There are a total of 116 questions, with the highest possible score being 580.

1. Add up the totals at the bottom of each page, and enter the sum in GRAND TOTAL.
2. Circle the appropriate range.

Ranges:

100 – 200 = Moderate or early stage FM/CFS

201 – 325 = Severe FM/CFS

326 – 580 = Extreme FM/CFS