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 my 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. _____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

(continued on next page)
_____ Skin condition --- What? ____________________________________________

_____ I tend to be anemic

_____ I have been diagnosed with a sleep disorder --- What? _______________________

_____ Took or take oral or injected contraceptives
  a. What? ________________________________________________________________
  b. When? ______________________________________________________________
  How long? _______________________

_____ I am menopausal or perimenopausal

_____ Took or take conventional HRT
  a. What? ______________________________________________________________
  b. When? ______________________________________________________________
  How long? _______________________

_____ Hysterectomy---Ovaries removed? _______________________________________

_____ 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

(continued on next 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
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 worthless
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 (continued on next page)
____ 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

GRAND TOTAL __________

RANGE:  Moderate  Severe  Extreme

HISTORY

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

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<th>Condition</th>
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List any surgeries or traumas you’ve had, and the dates.

________________________________________________________________Date__________
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List any medications you are taking.

______________________________________     ______________________________________
______________________________________     ______________________________________
______________________________________     ______________________________________
______________________________________     ______________________________________
______________________________________     ______________________________________
______________________________________     ______________________________________
______________________________________     ______________________________________
______________________________________     ______________________________________

List nutritional supplements, vitamins and herbs you are taking.

______________________________________     ______________________________________
______________________________________     ______________________________________
______________________________________     ______________________________________
______________________________________     ______________________________________
______________________________________     ______________________________________
______________________________________     ______________________________________
______________________________________     ______________________________________
______________________________________     ______________________________________

Describe anything you feel is contributing to your condition.

_____________________________________________________
_____________________________________________________
_____________________________________________________
_____________________________________________________
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Add anything else you have to say.

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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