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

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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

(continued on next page)

_____Less productive with work
_____Difficulty handling pressure or stress
_____Get sleepy during the day
_____Less energy for or interest in things I enjoy
_____Poor stamina
_____Trouble focusing on work or projects
_____Little or no energy for exercising
_____No energy left over for anything that I don't have to do
_____Do not feel well
_____Muscle pains/aches --- Where? _____
_____Muscle spasm --- Where? _____
_____Joint pains --- Where? _____
_____Numbness or tingling --- Where? _____
_____Burning pains --- Where? _____
_____Other pains --- Where? _____
_____Stiffness
_____Poor muscle strength or tone
_____Feel weak
_____Flu-like feelings
_____Exercise intolerance (excessive pain after exercise)
_____Prolonged fatigue after exertion
_____Increased pain sensitivity
_____Increased sensitivity to noise, light, touch
_____I have trouble slowing down or relaxing
_____Headaches or migraines
_____Neck or shoulder tension
_____Cold hands or feet
_____Tend to be cold all over
_____Indigestion
_____Bloating
_____Belching
_____Gas
_____Nausea
_____Acid reflux
_____Loss of taste for meat
_____Burning when stomach is empty
_____Gall bladder problems (removed)
_____Diarrhea
_____Constipation
_____Swollen lymph glands
_____Sore throat
_____Chronic sinus congestion
_____Chronic or recurring infections _____Total for this page

(continued on next 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 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

(continued on next page)

_____Arms and/or legs jerk when in bed
_____Grind teeth at night
_____Urinary frequency
_____Night-time urinary frequency
_____Urinary tract infection
_____Vaginal dryness, irritation or infections
_____Hot flashes
_____Night swears
_____PMS
_____Infertility
_____Heavy bleeding, clotting or cramping with periods
_____Irregular periods
_____Decreased libido
_____Erectile Dysfunction
_____Weight gain, especially around the middle
_____Unexplained weight loss
_____Bruise easily
_____Heavy legs/aching legs
_____Edema (water retention)
_____Become short of breath easily
_____Chest pain
_____Palpitations
_____Loneliness
_____Most people don't understand my condition
_____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_____

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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_____

(continued on next page)

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