

**UMDNJ - Pain and Fatigue Study Center**  
**CFS Patient Intake Form**

30 Bergen Street, ADMC 1618, Newark, NJ 07101  
Ph: 973-972 4800 Fax: 973-972 7656

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Today's date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Mobile: (\_\_\_\_) \_\_\_\_\_

E-mail address \_\_\_\_\_

Referred by \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of birth \_\_\_\_\_

Race (check one):

- \_\_\_ (1) White not Hispanic
- \_\_\_ (2) White Hispanic
- \_\_\_ (3) Black not Hispanic
- \_\_\_ (4) Black Hispanic
- \_\_\_ (5) Asian
- \_\_\_ (6) American Indian (Native Alaskan)
- \_\_\_ (7) Other, please specify

Employment status (check one):

- \_\_\_ (1) Full Time
- \_\_\_ (2) Part Time
- \_\_\_ (3) Unemployed, looking for work
- \_\_\_ (4) Unemployed due to health
- \_\_\_ (5) Retired (for any reason)
- \_\_\_ (6) Never worked outside home
- \_\_\_ (7) Other, please specify

Marital status (check one):

- \_\_\_ (1) Married
- \_\_\_ (2) Divorced
- \_\_\_ (3) Never married
- \_\_\_ (4) Widowed
- \_\_\_ (5) Separated
- \_\_\_ (6) Living as married

1. Do you have a condition that causes lack of energy, fatigue, or a general feeling of not being well?  
\_\_\_ Yes \_\_\_ No

If yes, when did this begin? Month \_\_\_\_\_ Year \_\_\_\_\_

Did you see a doctor for this? \_\_\_ Yes \_\_\_ No

What did the doctor say about it? \_\_\_\_\_

\_\_\_\_\_

2. Do you have a condition that causes widespread pain? \_\_\_ Yes \_\_\_ No

If yes, when did this condition begin? Month \_\_\_\_\_ Year \_\_\_\_\_

Did you see a doctor for this condition? \_\_\_ Yes \_\_\_ No

What did the doctor say about it? \_\_\_\_\_

\_\_\_\_\_

3. Prior to your current condition, have you ever had a problem with severe fatigue or pain in the past (for example, mono)? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please provide details and date(s) of occurrence: \_\_\_\_\_  
 \_\_\_\_\_

Did you see a doctor for this condition? \_\_\_\_\_ Yes \_\_\_\_\_ No

What did the doctor say about it? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. How did your fatigue or widespread pain start?

\_\_\_\_\_ Gradually, no clear onset.

\_\_\_\_\_ Suddenly (over the course of hours or days), with a “flu”, cold or virus characterized by two or more of the following; fever, headache, muscle aches, earache, sore throat, congestion, runny nose, cough, diarrhea or fatigue.

\_\_\_\_\_ Suddenly (over the course of hours or days), with no other symptoms.

\_\_\_\_\_ I cannot remember.

5. **Over the last 3 months**, have you had pain in your muscles, bones or joints lasting at least 1 week?

\_\_\_\_\_ Yes \_\_\_\_\_ No [if no, skip to question 6]

**In the past 3 months: [circle one number in EACH ROW]**

	No	Yes, left side of body	Yes, right side of body	Yes, both left and right side of body
...have you had pain in your shoulders, arms or hands?	0	1	2	3
...have you had pain in your legs or feet?	0	1	2	3
...have you had pain in your chest, neck or back?	0	1	2	3

6. For how many months has each of the following symptoms lasted or recurred since your present condition began? Please **circle the number of months for each symptom**:

	Number of months						
	0	1-3	4-5	6-8	9-10	11-12	13 or more
Chills or fever	0	1-3	4-5	6-8	9-10	11-12	13 or more
Sore throat	0	1-3	4-5	6-8	9-10	11-12	13 or more
Tender glands (lumps either felt by you or your doctor in neck jaw or armpits)	0	1-3	4-5	6-8	9-10	11-12	13 or more
New types of headaches	0	1-3	4-5	6-8	9-10	11-12	13 or more
Muscle discomfort or pains	0	1-3	4-5	6-8	9-10	11-12	13 or more
Unexplained weakness in many muscles	0	1-3	4-5	6-8	9-10	11-12	13 or more
Pain in joints such as elbows, knees and fingers without redness or swelling	0	1-3	4-5	6-8	9-10	11-12	13 or more
Prolonged fatigue or feeling of illness lasting longer than a day after mild exercise	0	1-3	4-5	6-8	9-10	11-12	13 or more
Unrefreshing sleep	0	1-3	4-5	6-8	9-10	11-12	13 or more
Substantial problems with short term memory or concentration	0	1-3	4-5	6-8	9-10	11-12	13 or more
Shortness of breath	0	1-3	4-5	6-8	9-10	11-12	13 or more
Stomach or digestive troubles	0	1-3	4-5	6-8	9-10	11-12	13 or more
Hot flashes	0	1-3	4-5	6-8	9-10	11-12	13 or more
Inability to hold urine	0	1-3	4-5	6-8	9-10	11-12	13 or more



9. Rate the degree to which you have had the following symptoms ***IN THE PAST MONTH?*** Please rate each on a scale of 0 to 5: **WHERE 0 = NONE, 1 = MILD, 2 = MODERATE, 3 = SUBSTANTIAL, 4 = SEVERE, AND 5 = VERY SEVERE**

	(circle one)					
Feeling feverish	0	1	2	3	4	5
Chills (If so, are the chills a teeth-chattering type? ___ yes ___ no)	0	1	2	3	4	5
Tender glands (lumps either felt by you or your doctor in the neck/jaw or armpits )	0	1	2	3	4	5
Sore Throat	0	1	2	3	4	5
Headaches that are different from those you may have had before the CFS	0	1	2	3	4	5
Muscle discomfort or pains	0	1	2	3	4	5
Unexplained weakness in many muscles	0	1	2	3	4	5
Pain in more than one joint without redness or swelling (elbow, knee, shoulder etc)	0	1	2	3	4	5
Prolonged fatigue or a feeling of illness after mild exercise (lasting longer than 24 hours)	0	1	2	3	4	5
Unrefreshing sleep	0	1	2	3	4	5
Shortness of breath or difficulty breathing	0	1	2	3	4	5
Stomach or digestive troubles	0	1	2	3	4	5
Skin Rashes	0	1	2	3	4	5
Inability to hold urine	0	1	2	3	4	5

10. To what degree have short-term memory or concentration problems affected your OCCUPATIONAL, EDUCATIONAL, SOCIAL OR PERSONAL ACTIVITY LEVEL on a scale of 0 to 5 (Circle One).

None	Mild	Moderate	Substantial	Severe	Very Severe
0	1	2	3	4	5

11. Indicate **how often, if at all**, the following statements apply. (In these statements "ill" means having symptoms such as upset stomach, headache, dizziness, or muscle/joint pain.)

	<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>
I feel ill from the odor of pesticide.	0	1	2	3	4
I feel ill from the odor of car exhaust.	0	1	2	3	4
I feel ill from the odor of cologne, aftershave or perfume.	0	1	2	3	4
I feel ill from walking into a room with a brand new carpet.	0	1	2	3	4
I feel ill from the odor of paint.	0	1	2	3	4
I feel ill from walking down the detergent aisle in the grocery store.	0	1	2	3	4
I feel ill from walking into a beauty parlor or barber shop.	0	1	2	3	4
I feel ill from reading a freshly printed newspaper.	0	1	2	3	4

12. Please rate how the following list of products or situations that affect your health. In these statements, sick means that you get a headache, an upset stomach, dizziness, or something similar. If you don't know how these products or situations make you feel, then indicate that on the scale.

	<b>No problem</b>	<b>Bothers me</b>	<b>A little sick</b>	<b>Very sick</b>	<b>Don't know</b>	<b>Not applicable</b>
Cologne, aftershave or perfume.	1	2	3	4	5	6
Walking down the detergent aisle at the grocery store.	1	2	3	4	5	6
Going into a beauty salon or barber shop.	1	2	3	4	5	6
Walking into a room with brand new carpets.	1	2	3	4	5	6
Reading freshly printed newspaper.	1	2	3	4	5	6
Sitting in a room where someone else is smoking.	1	2	3	4	5	6
Using ammonia or chlorine bleach around the house.	1	2	3	4	5	6
Using bug spray in the house.	1	2	3	4	5	6
Waiting for the traffic light to turn green and smelling the car and bus exhaust.	1	2	3	4	5	6
Using a bathroom with a scented air freshener.	1	2	3	4	5	6

13. Compared to other people, do you consider yourself unusually sensitive to everyday chemicals like those in household cleaning supplies, paints, perfumes, soaps, garden sprays or things like that?  
\_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ Don't know

14. **Because of chemical sensitivities.....**

	NO	YES	DONT KNOW
a. Do you now need to follow a special diet?	_____	_____	_____
b. Do you now take special precautions in your home or with your home furnishings?	_____	_____	_____
c. Do you now need to wear or avoid wearing particular clothes?	_____	_____	_____
d. Do you have trouble shopping in stores or eating in restaurants?	_____	_____	_____

15. Do you currently have any other serious medical conditions (for example, diabetes, lupus, rheumatoid arthritis, thyroid disorder, multiple sclerosis, heart disease, asthma, cancer, HIV)? \_\_\_\_ Yes \_\_\_\_ No

If **yes**, please list:

- a) \_\_\_\_\_
- b) \_\_\_\_\_
- c) \_\_\_\_\_
- d) \_\_\_\_\_

16. Are you currently taking any medications (including both over-the-counter and prescription)?  
\_\_\_\_ Yes \_\_\_\_ No

If **yes**, please list the name, dosage, reason, and how long you have been taking the medication.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17. Have you ever been hospitalized? \_\_\_\_\_ Yes \_\_\_\_\_ No

If **yes**, please list reason and year:

- a) \_\_\_\_\_
- b) \_\_\_\_\_
- c) \_\_\_\_\_
- d) \_\_\_\_\_

18. Have you ever had trauma or injury to your head, which resulted in a loss of consciousness?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

a. If yes, how long were you unconscious (# of minutes, hours, or days)? \_\_\_\_\_

b. Did you lose memory for events immediately before the accident? \_\_\_\_\_ Yes \_\_\_\_\_ No

If **yes**, for how long before the event? \_\_\_\_\_

Did you lose memory for events immediately after the accident? \_\_\_\_\_ Yes \_\_\_\_\_ No

If **yes**, for how long after the event? \_\_\_\_\_

c. At the time of the trauma or injury did you feel dazed? \_\_\_\_\_ Yes \_\_\_\_\_ No

disoriented? \_\_\_\_\_ Yes \_\_\_\_\_ No

confused? \_\_\_\_\_ Yes \_\_\_\_\_ No

d. After the trauma, did you have weakness or numbness on one side of the body? \_\_\_\_\_ Yes \_\_\_\_\_ No

After the trauma, did you have difficulty finding or understanding words? \_\_\_\_\_ Yes \_\_\_\_\_ No

19. Have you had a problem with alcohol or recreational drug use in the **2 years prior to the onset of your condition**? \_\_\_\_\_ Yes \_\_\_\_\_ No

a. In **the 2 years prior to the onset of your condition**, did you ever need to make an effort to cut down on alcohol or drug use? \_\_\_\_\_ Yes \_\_\_\_\_ No

b. In **the 2 years prior to the onset of your condition**, did you ever have to give up or reduce important social or work activities because of alcohol or drug use? \_\_\_\_\_ Yes \_\_\_\_\_ No

c. In **the 2 years prior to the onset of your condition**, were you ever annoyed by someone's criticism of your drinking or recreational drug use? \_\_\_\_\_ Yes \_\_\_\_\_ No

d. In **the 2 years prior to the onset of your condition**, did the use of alcohol or other substances ever interfere with your relationship with family or friends? \_\_\_\_\_ Yes \_\_\_\_\_ No

20. Psychiatric History: List any in or outpatient treatment by a psychiatrist, psychologist, counselor, social worker, etc. Also note the reason for therapy and type of treatment.

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21. In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the past month*, you...

a) Have had nightmares about it or thought about it when you did not want to? \_\_\_\_\_ Yes \_\_\_\_\_ No

b) Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

c) Were constantly on guard, watchful, or easily startled? \_\_\_\_\_ Yes \_\_\_\_\_ No

d) Felt numb or detached from others, activities, or your surroundings? \_\_\_\_\_ Yes \_\_\_\_\_ No

If you said Yes to any of the above, when did these symptoms begin (month/year)? \_\_\_\_\_



**SELF EVALUATION QUESTIONNAIRE**  
**STAI Form Y-2**

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then circle appropriate statement to indicate how you generally feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

**1=Almost Never, 2=Sometimes, 3=Often 4=Almost always**

	Almost Never	Sometimes	Often	Almost	Always
21. I feel pleasant .....	1	2	3		4
22. I feel nervous and restless .....	1	2	3		4
23. I feel satisfied with myself .....	1	2	3		4
24. I wish I could be as happy as others seem to be..	1	2	3		4
25. I feel like a failure .....	1	2	3		4
26. I feel rested .....	1	2	3		4
27. I am "calm, cool, and collected .....	1	2	3		4
28. I feel that difficulties are piling up so that I cannot overcome them .....	1	2	3		4
29. I worry too much over something that really doesn't matter.....	1	2	3		4
30. I am happy .....	1	2	3		4
31. I have disturbing thoughts .....	1	2	3		4
32. I lack self confidence .....	1	2	3		4
33. I feel secure .....	1	2	3		4
34. I make decisions easily .....	1	2	3		4
35. I feel inadequate .....	1	2	3		4
36. I am content .....	1	2	3		4
37. Some unimportant thought runs through my mind and bothers me .....	1	2	3		4
38. I take disappointments so keenly that I can't put them out of my mind .....	1	2	3		4
39. I am a steady person .....	1	2	3		4
40. I get in a state of tension or turmoil as I think over my recent concerns and interests .....	1	2	3		4

## Medical History by Organ Systems

Have you ever been told by a doctor that you had any of the following conditions?

### Cardiovascular

Heart murmur        \_\_\_ Yes \_\_\_ No  
Angina                \_\_\_ Yes \_\_\_ No  
Heart attack        \_\_\_ Yes \_\_\_ No  
High blood pressure \_\_\_ Yes \_\_\_ No  
Vascular disease in  
arms/legs            \_\_\_ Yes \_\_\_ No  
Atypical chest pain \_\_\_ Yes \_\_\_ No  
Other, specify        \_\_\_ Yes \_\_\_ No

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### Gastrointestinal

Peptic ulcer        \_\_\_ Yes \_\_\_ No  
Hiatus hernia      \_\_\_ Yes \_\_\_ No  
Hepatitis            \_\_\_ Yes \_\_\_ No  
Gall bladder disease \_\_\_ Yes \_\_\_ No  
Liver disease        \_\_\_ Yes \_\_\_ No  
Cirrhosis            \_\_\_ Yes \_\_\_ No  
Pancreatitis        \_\_\_ Yes \_\_\_ No  
Irritable Bowel  
Syndrome            \_\_\_ Yes \_\_\_ No  
Colitis                \_\_\_ Yes \_\_\_ No  
Other, specify        \_\_\_ Yes \_\_\_ No

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### Skin

Hives                \_\_\_ Yes \_\_\_ No  
Psoriasis            \_\_\_ Yes \_\_\_ No  
Eczema              \_\_\_ Yes \_\_\_ No  
Contact dermatitis \_\_\_ Yes \_\_\_ No  
Other allergic skin  
reactions            \_\_\_ Yes \_\_\_ No  
Other, specify        \_\_\_ Yes \_\_\_ No

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### Genitourinary

Nephritis            \_\_\_ Yes \_\_\_ No  
Kidney disease     \_\_\_ Yes \_\_\_ No  
Indicate type \_\_\_\_\_  
Repeated urinary  
Infection            \_\_\_ Yes \_\_\_ No  
Kidney/bladder  
stones                \_\_\_ Yes \_\_\_ No  
Vasectomy          \_\_\_ Yes \_\_\_ No  
Blood/protein in  
urine                 \_\_\_ Yes \_\_\_ No  
Venereal disease    \_\_\_ Yes \_\_\_ No  
D.E.S./son or  
Daughter            \_\_\_ Yes \_\_\_ No  
Yeast infections    \_\_\_ Yes \_\_\_ No  
Other, specify        \_\_\_ Yes \_\_\_ No

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### Blood

Anemia              \_\_\_ Yes \_\_\_ No  
Problems with blood  
clotting/bleeding   \_\_\_ Yes \_\_\_ No  
Sickle cell          \_\_\_ Yes \_\_\_ No  
Thalassemia        \_\_\_ Yes \_\_\_ No  
Other, specify        \_\_\_ Yes \_\_\_ No

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### Eye

Require glasses    \_\_\_ Yes \_\_\_ No  
Glaucoma            \_\_\_ Yes \_\_\_ No  
Cataracts            \_\_\_ Yes \_\_\_ No  
Optic neuritis      \_\_\_ Yes \_\_\_ No  
Eye infections      \_\_\_ Yes \_\_\_ No  
Other, specify        \_\_\_ Yes \_\_\_ No

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Have you ever been told by a doctor that you had any of the following conditions?

Pulmonary

Pneumonia            \_\_\_ Yes \_\_\_ No  
Pleurisy             \_\_\_ Yes \_\_\_ No  
Asthma (as a child) \_\_\_ Yes \_\_\_ No  
Asthma (as an adult) \_\_\_ Yes \_\_\_ No  
Bronchitis          \_\_\_ Yes \_\_\_ No  
Emphysema         \_\_\_ Yes \_\_\_ No  
Tuberculosis        \_\_\_ Yes \_\_\_ No  
Silicosis            \_\_\_ Yes \_\_\_ No  
Asbestosis          \_\_\_ Yes \_\_\_ No  
Other, specify      \_\_\_ Yes \_\_\_ No

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Nervous System

Seizure disorders   \_\_\_ Yes \_\_\_ No  
Migraine            \_\_\_ Yes \_\_\_ No  
Other headache  
syndrome            \_\_\_ Yes \_\_\_ No  
Multiple Sclerosis   \_\_\_ Yes \_\_\_ No  
Neuritis             \_\_\_ Yes \_\_\_ No  
Peripheral neuropathy \_\_\_ Yes \_\_\_ No  
Head injury with loss  
of consciousness    \_\_\_ Yes \_\_\_ No  
Other, specify      \_\_\_ Yes \_\_\_ No

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Ear, Nose & Throat

Chronic sinusitis   \_\_\_ Yes \_\_\_ No  
Impaired hearing    \_\_\_ Yes \_\_\_ No  
Easy nasal bleeding \_\_\_ Yes \_\_\_ No  
Nasal allergies     \_\_\_ Yes \_\_\_ No  
Tonsillectomy      \_\_\_ Yes \_\_\_ No  
Hay fever            \_\_\_ Yes \_\_\_ No  
Other, specify      \_\_\_ Yes \_\_\_ No

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Cancer

Please list site:     \_\_\_ Yes \_\_\_ No

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General

Hypoglycemia        \_\_\_ Yes \_\_\_ No  
Infectious Mononucleosis  
                                 \_\_\_ Yes \_\_\_ No  
Breast lumps         \_\_\_ Yes \_\_\_ No  
Thyroid disease/  
goiter                \_\_\_ Yes \_\_\_ No  
Diabetes              \_\_\_ Yes \_\_\_ No  
Gout                  \_\_\_ Yes \_\_\_ No  
Hemorrhoids         \_\_\_ Yes \_\_\_ No  
Hernia, specify type \_\_\_ Yes \_\_\_ No

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Musculoskeletal

Rheumatoid arthritis \_\_\_ Yes \_\_\_ No  
Other arthritis      \_\_\_ Yes \_\_\_ No  
Lupus                \_\_\_ Yes \_\_\_ No  
Back injury         \_\_\_ Yes \_\_\_ No  
Low back syndrome \_\_\_ Yes \_\_\_ No  
Neck pain/injury    \_\_\_ Yes \_\_\_ No  
Degenerative disc  
disease               \_\_\_ Yes \_\_\_ No  
Sciatica/disc  
herniation           \_\_\_ Yes \_\_\_ No  
Bone lesion/  
infections           \_\_\_ Yes \_\_\_ No  
History of broken  
bones                \_\_\_ Yes \_\_\_ No  
Other, specify      \_\_\_ Yes \_\_\_ No

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Skin cancer/non-melanoma,  
specify type        \_\_\_ Yes \_\_\_ No

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Dental/gum problems,  
specify type        \_\_\_ Yes \_\_\_ No

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Mumps, age \_\_\_\_\_ \_\_\_ Yes \_\_\_ No

Adverse reactions to exposure to heat  
i.e. heat exhaustion or heat stroke

                                 \_\_\_ Yes \_\_\_ No

Frequent night sweats  
or fever              \_\_\_ Yes \_\_\_ No

Other, specify      \_\_\_ Yes \_\_\_ No

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## MEDICAL HISTORY

### HOSPITALIZATIONS – LIST ALL PREVIOUS HOSPITALIZATIONS, INCLUDING SURGERY AND PSYCHIATRIC HOSPITALIZATIONS

REASON FOR TREATMENT ADMISSION (DIAGNOSIS)	DATE	HOSPITAL	NAME/CITY
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

### PSYCHIATRIC HISTORY – LIST ANY OUTPATIENT TREATMENT BY A PSYCHIATRIST, PSYCHOLOGY, COUNSELOR, SOCIAL WORKER, ETC.

REASON FOR TREATMENT THERAPY	DATE FROM/TO	FACILITY/PERSON
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

## Sleep Disturbances

Sleep problems are common in Chronic Fatigue Syndrome. This questionnaire is designed to help us evaluate your sleep patterns and determine if referral to a sleep disorder clinic and further testing might be useful. Please indicate below if you currently have any of the following problems:

	<i>Check one:</i>	<b>Yes</b>	<b>No</b>	<b>Don't Know</b>
1.	Chronic, loud, irregular snoring			
2.	Snoring of any type with your bed partner observing irregular breathing			
3.	Daytime sleepiness present on an almost daily basis			
4.	Daytime sleepiness at inappropriate times, such as while driving or talking.			
5.	Any history of persistent, irresistible sleep attacks.			
6.	Strange sensations in your legs as you fall asleep which are only relieved by moving your legs - "restless leg syndrome".			
7.	A history of persistent daily drowsiness which you can resist but can be followed by voluntary napping			
8.	Consistently broken, restless, unrefreshing sleep			
9.	Frequent awakenings after you fall asleep which last at least 20 minutes and occur at least 3 times each night at least 4 night per week.			
10.	A reduction of 30% in your total sleep time or less than 5 hours of sleep at least 4 nights per week.			

**THE FOLLOWING QUESTION REFERS TO HOW YOUR MOOD  
AND  
BEHAVIOR VARIES OVER THE DIFFERENT SEASONS.**

FOR INSTANCE,  
SOME PEOPLE FEEL BETTER IN ONE SEASON THAN THEY DO IN OTHER SEASONS.

Below, please specify to what degree the following change with the seasons.

	<b>No Change</b>	<b>Slight Change</b>	<b>Moderate Change</b>	<b>Marked Change</b>	<b>Extremely Marked Change</b>
A. Sleep Length					
B. Social Activity					
C. Mood (Overall level of well being)					
D. Weight					
E. Appetite					
F. Energy Level					

## CES-D

Circle the number for each statement which best describes how often you felt or behaved this way –  
**DURING THE PAST WEEK**

	During the past week:	Rarely or None of the Time (less than 1 day)	Some or Little of The Time (1-2 days)	Occasionally Or a moderate Amount of time (3-4 days)	Most Of the Time (5-7 days)
1	I was bothered by things that usually don't bother me	0	1	2	3
2	I did not feel like eating; my appetite was Poor	0	1	2	3
3	I felt that I could not shake off the blues even with help from my family	0	1	2	3
4	I felt that I was just as good as other people	0	1	2	3
5	I had trouble keeping my mind on what I was doing	0	1	2	3
6	I felt depressed	0	1	2	3
7	I felt that everything I did was an effort	0	1	2	3
8	I felt that hopeful about the future	0	1	2	3
9	I thought my life has been a failure	0	1	2	3
10	I felt fearful	0	1	2	3
11	My sleep was restless	0	1	2	3
12	I was happy	0	1	2	3
13	I talked less than usual	0	1	2	3
14	I felt lonely	0	1	2	3
15	People were unfriendly	0	1	2	3
16	I enjoyed life	0	1	2	3
17	I had crying spells	0	1	2	3
18	I felt sad	0	1	2	3
19	I felt that people disliked me	0	1	2	3
20	I could not get "going"	0	1	2	3

# WPS Inventory

**SURVEY INSTRUCTIONS:** Please answer each question by checking the circle or following the given directions. If you are unsure about how to answer a question, please give the best answer you can. Thank you for your responses.

1) Below is a list of physical troubles. Please indicate how often each of these bothers you. Do this by circling the number to the right of each trouble which shows how often you are bothered by that trouble. Keep in mind that the LARGER the number the MORE OFTEN the trouble bothers you. Please DO NOT SKIP any troubles.

		Almost never	About once a year	About once a month	About once a week	About twice a week	Nearly every day
1	Nausea (Feeling like throwing up)	0	1	2	3	4	5
2	Headaches	0	1	2	3	4	5
3	Trouble with ears or hearing	0	1	2	3	4	5
4	Neck aches or pains	0	1	2	3	4	5
5	Feeling hot or cold regardless of weather	0	1	2	3	4	5
6	Arm or leg aches or pains	0	1	2	3	4	5
7	Shakiness	0	1	2	3	4	5
8	Swelling of arms, hands, legs or feet	0	1	2	3	4	5
9	Stuttering or stammering	0	1	2	3	4	5
10	Difficulty sleeping	0	1	2	3	4	5
11	Losing weight	0	1	2	3	4	5
12	Backaches	0	1	2	3	4	5
13	Intestinal or stomach trouble	0	1	2	3	4	5
14	Difficulty with urination (Passing water)	0	1	2	3	4	5
15	Heart trouble	0	1	2	3	4	5
16	Trouble with teeth	0	1	2	3	4	5
17	Numbness, or lack of feeling in any part of the body	0	1	2	3	4	5
18	Aches or pains in hands or feet	0	1	2	3	4	5
19	Fainting spells	0	1	2	3	4	5
20	Excessive perspiration	0	1	2	3	4	5
21	Abnormal blood pressure	0	1	2	3	4	5
22	Paralysis (Unable to move parts of the body)	0	1	2	3	4	5
23	Trouble with eyes or vision	0	1	2	3	4	5
24	Burning, tingling or crawling feelings in the skin	0	1	2	3	4	5
25	Skin trouble (Rashes, boils or itching)	0	1	2	3	4	5

		Almost never	About once a year	About once a month	About once a week	About twice a week	Nearly every day
26	Feeling tired	0	1	2	3	4	5
27	Muscular weakness	0	1	2	3	4	5
28	Dizzy spells	0	1	2	3	4	5
29	Muscular tensions	0	1	2	3	4	5
30	Any trouble with the senses of taste or smell	0	1	2	3	4	5
31	Difficulty breathing (Short of breath, asthma, etc.)	0	1	2	3	4	5
32	Twitching muscles	0	1	2	3	4	5
33	Poor health in general	0	1	2	3	4	5
34	Excessive gas	0	1	2	3	4	5
35	Difficulty swallowing	0	1	2	3	4	5
36	Seizures (Convulsions or fits)	0	1	2	3	4	5
37	Gaining weight	0	1	2	3	4	5
38	Difficulty with appetite	0	1	2	3	4	5
39	Bowel trouble (Constipation or loose bowels)	0	1	2	3	4	5
40	Vomiting	0	1	2	3	4	5
41	Chest pains	0	1	2	3	4	5
42	Hay fever or other allergies	0	1	2	3	4	5
43	Cough	0	1	2	3	4	5
44	Sores in mouth and genitals	0	1	2	3	4	5
45	Palpitations	0	1	2	3	4	5
46	Sensitivity to cold or heat	0	1	2	3	4	5
47	Weight change of 15 lbs or more	0	1	2	3	4	5
48	Need to urinate at night	0	1	2	3	4	5
49	Menstrual cramps or other problems with your periods	0	1	2	3	4	5
50	Lightheaded while standing	0	1	2	3	4	5