Please note that all answers will be kept confidential. You can complete this form on your computer. When you are done, print it out and FAX it to 212-844-6724.

Pain and Fatigue Study Center

CFS Patient Intake Form

Dr. Benjamin Natelson
Beth Israel Medical Center
Phillips Ambulatory Care Center, Suite 5D
10 Union Square East, New York, NY 10003
Phone: 212-844-6665 Fax: 212-844-6724

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?
◯ Yes ◯ No **[if no, skip to question 6]**

Check EACH of the areas below that have been painful in the past 3 months.

☐ **Left Shoulder**	☐ **Left Hip or Buttock**	☐ **Left Jaw**	☐ **Upper back**
☐ **Right Shoulder**	☐ **Right Hip or Buttock**	☐ **Right Jaw**	☐ **Lower back**
☐ **Left Upper Arm**	☐ **Left Upper Leg**	☐ **Chest**	☐ **Neck**
☐ **Right Upper Arm**	☐ **Right Upper Leg**	☐ **Abdomen or Belly**	

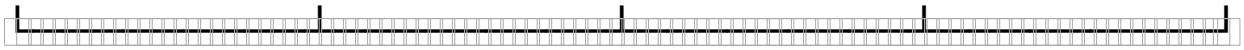
6. For how many months has each of the following symptoms lasted or recurred since your present condition began? Please **choose the number of months for each symptom**:

	Number of months						
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

7. Please rate each on a scale of 0 to 5: **WHERE 0 =NO EFFECT, 1=MILD EFFECT, 2=MODERATE EFFECT, 3=SUBSTANTIAL EFFECT, 4=SEVERE EFFECT, AND 5 =VERY SEVERE EFFECT**

	(Choose One)					
In the past six months, what effect has your fatigue had on your level of activity **on the job**?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
In the past six months, what effect has your fatigue had on your level of activity **in school or class**?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
In the past six months, what effect has your fatigue had on your level of **social** activity?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
In the past six months, what effect has your fatigue had on your level of activity **in your personal** life?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
In the past six months, what effect has your widespread pain had on your level of activity **on the job**?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
In the past six months, what effect has your widespread pain had on your level of activity **in school or class**?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
In the past six months, what effect has your widespread pain had on your level of **social** activity?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
In the past six months, what effect has your widespread pain had on your level of activity **in your personal life**?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5

8. To what degree has your **fatigue** limited your daily activity over the past six months? Please click or write to mark an "X" on the scale.



0%	25%	50%	75%	100%
Normal overall activity level; No limitations		Level reduced to 50% of normal		Totally disabled bed ridden constantly

To help us determine if you have migraine, please answer yes or no to each of the following:	**YES**	**NO**
Has a headache limited your activities for a day or more in the last three months?	◯	◯
Are you nauseated or sick to your stomach when you have a headache?	◯	◯
Does light bother you when you have a headache?	◯	◯
If you have headaches, how many of these did you have last month?	_____	

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**

	(Choose 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 (CHOOSE ONE ANSWER).

○ None ○ Mild ○ Moderate ○ Substantial ○ Severe ○ Very Severe

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.)

	Never	Rarely	Sometimes	Often	Always
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.

	No problem	Bothers me	A little sick	Very sick	Don't know	Not applicable
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.....**

a. Do you now need to follow a special diet?	◯ No	◯ Yes	◯ Don't know
b. Do you now take special precautions in your home or with your home furnishings?	◯ No	◯ Yes	◯ Don't know
c. Do you now need to wear or avoid wearing particular clothes?	◯ No	◯ Yes	◯ Don't know
d. Do you have trouble shopping in stores or eating in restaurants?	◯ No	◯ Yes	◯ Don't know

15. **Irritable Bowl Syndrome**
Do you have? (If yes, please indicate if for 3 months or more or if recurrently)

a) Abdominal pain or discomfort relieved with passing stool?

◯ No ◯ Yes ◯ 3months or more ◯ Recurrently

b) Abdominal pain or discomfort with change in consistency of stool?

◯ No ◯ Yes ◯ 3months or more ◯ Recurrently

c) Abdominal pain or discomfort with change in frequency of stool?

◯ No ◯ Yes ◯ 3months or more ◯ Recurrently

16. 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)_____

17. 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.

_____
_____
_____

18. Have you ever been hospitalized? ◯ Yes ◯ No

If **yes**, please list reason and year:
a) _____
b) _____
c) _____
d) _____

19. 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

20. 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

21. 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.

_____
_____
_____

22. In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the <u>past month</u>,* 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)? _____

23. Have you ever had a period of time when you were feeling depressed or down most of the day nearly every day? ◯ Yes ◯ No

If yes, how long did this last? _____ Days _____ Weeks _____ Months

24. Have you ever had a period where you were less interested in most things or unable to enjoy the things you used to enjoy? ◯ Yes ◯ No

If yes, did you feel this way nearly every day? ◯ Yes ◯ No
How long did this last? _____ Days _____ Weeks _____ Months

25. Have you ever had a panic attack? (When you suddenly felt frightened, anxious, or extremely uncomfortable; usually accompanied by rapid breathing, palpitations, and sweating) ◯ Yes ◯ No

If yes, give details. When did it happen? _____
_____

Did you ever have one that just seemed to happen for no particular reason? ◯ Yes ◯ No

Did you ever have four attacks like that in a four weeks period? ◯ Yes ◯ No

The Pain and Fatigue Study Center currently conducts numerous research studies. If you would like a Study Coordinator to contact you to discuss participation in research please initial here. _____.

If you are interested in private care, please understand that Dr Natelson accepts Medicare only. For all other patients, payment is required at the time of the visit. A fee will be charged if you do not come to the visit without providing 48 hr notice. Please contact your insurance company if applicable before your appointment to determine Out of Network benefits and to arrange for necessary referrals and/or authorization.

Please initial here and someone from Dr. Natelson's office will contact you _____.

What is the best way to reach you?

○ **Phone:** **Home** _____
(time & day)
Work _____
(time & day)
Mobile_____
(time & day)

○ **Email:** _____

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

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

Skin

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

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

Blood

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

Eye

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

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

_____

_____

Ear, Nose, and 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

_____

_____

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

_____

_____

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

_____

_____

Cancer

Please list site:	◯ Yes	◯ No

_____

_____

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

_____

Skin cancer/non-melanoma, Specify type	◯ Yes	◯ No

_____

Dental/gum problems, Specify type	◯ Yes	◯ No

_____

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

_____

_____

MEDICAL HISTORY

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

REASON FOR TREATMENT ADMISSION (DIAGNOSIS)	DATE	HOSPITAL	NAME/CITY

1. _____

2. _____

3. _____

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. _____

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.

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

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:

	Choose one:	**Yes**	**No**	**Don't Know**
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.	○	○	○

Insomnia Severity Index

Please rate the current (i.e., last 2 weeks) SEVERITY of your sleeping problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	◯	◯	◯	◯	◯
2. Difficulty staying asleep	◯	◯	◯	◯	◯
3. Problems waking up too early	◯	◯	◯	◯	◯

4. How **SATISFIED/DISATISFIED** are you with your current sleep pattern?
   ◯ Very Satisfied ◯ Satisfied ◯ Moderately Satisfied ◯ Dissatisfied ◯ Very Dissatisfied

5. How **NOTICEABLE** to others do you think your sleeping problem is in terms of impairing the quality of your life?
   ◯ Not at all Noticeable ◯ A Little ◯ Somewhat ◯ Much ◯ Very Much Noticeable

6. How **WORRIED/DISTRESSED** are you about your current sleep problem?
   ◯ Not at all Worried ◯ A Little ◯ Somewhat ◯ Much ◯ Very Much Worried

7. To what extent do you consider your sleep problem to **INTERFERE** with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.) **CURRENTLY**?
   ◯ Not at all Interfering ◯ A Little ◯ Somewhat ◯ Much ◯ Very Much Interfering

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 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.

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)**	○	○	○	○	○	○
2	**Headaches**	○	○	○	○	○	○
3	**Trouble with ears or hearing**	○	○	○	○	○	○
4	**Neck aches or pains**	○	○	○	○	○	○
5	**Feeling hot or cold regardless of weather**	○	○	○	○	○	○
6	**Arm or leg aches or pains**	○	○	○	○	○	○
7	**Shakiness**	○	○	○	○	○	○
8	**Swelling of arms, hands, legs, or feet**	○	○	○	○	○	○
9	**Stuttering or stammering**	○	○	○	○	○	○
10	**Difficulty sleeping**	○	○	○	○	○	○
11	**Losing weight**	○	○	○	○	○	○
12	**Back aches**	○	○	○	○	○	○
13	**Intestinal or stomach trouble**	○	○	○	○	○	○
14	**Difficulty with urination (Passing water)**	○	○	○	○	○	○
15	**Heart trouble**	○	○	○	○	○	○
16	**Trouble with teeth**	○	○	○	○	○	○
17	**Numbness, or lack of feeling in any part of the body**	○	○	○	○	○	○
18	**Aches or pains in hands or feet**	○	○	○	○	○	○
19	**Fainting spells**	○	○	○	○	○	○
20	**Excessive perspiration**	○	○	○	○	○	○
21	**Abnormal blood pressure**	○	○	○	○	○	○
22	**Paralysis (Unable to move parts of the body)**	○	○	○	○	○	○
23	**Trouble with eyes or vision**	○	○	○	○	○	○
24	**Burning, tingling, or crawling feeling of the skin**	○	○	○	○	○	○
25	**Skin trouble (Rashes, boils, or itching)**	○	○	○	○	○	○

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