DePaul Symptom Questionnaire 2 (DSQ-2)

Research · August 2019

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DePaul Symptom Questionnaire (DSQ-2)

New items are highlighted in grey

1. What is your height?_____

2. What is your weight?_____

3. What is your date of birth?_____

4. What is your gender?_____

5. To which of the following race(s) do you belong? Select all that apply.

- ☐ Black, African-American
- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Other race (*Please specify*)_____

6. Are you of Latino or Hispanic origin?

☐ Yes ☐ No

7. What is your current marital status?

- ☐ Married or living with partner
- ☐ Separated
- ☐ Widowed
- ☐ Divorced
- ☐ Never married

8. Do you have any children?

☐ Yes ☐ No (*Skip to Question 9)*

8a. How many children do you have?_____

8b. How many of your children are under 18 years old?_____

9. How many people live in your home?_____

10. What grade or degree have you completed in school?

- ☐ Less than high school
- ☐ Some high school
- ☐ High school degree or GED
- ☐ Partial college (at least one year) or specialized training
- ☐ Standard college degree
- ☐ Graduate professional degree including masters and doctorate

11. What is your current work status? Select all that apply.

- ☐ On disability
- ☐ Student
- ☐ Homemaker
- ☐ Retired
- ☐ Unemployed
- ☐ Working part-time
- ☐ Working full-time

11a. If you are on disability, for what condition do you receive disability compensation?

Please Specify_____

12. What is your current occupation?

Current_____

12a. If you are currently not working, what was your most recent occupation?

Most Recent_____

For each symptom below, please circle **one number for frequency** and **one number for severity**:

Please complete the chart from left to right.

Frequency:	*Severity:*
Throughout the **past 6 months**, **how often** have you had this symptom? For each symptom listed below, circle a number from: **0 = none of the time** **1 = a little of the time** **2 = about half the time** **3 = most of the time** **4 = all of the time**	Throughout the **past 6 months**, **how much** has this symptom bothered you? For each symptom listed below, circle a number from: **0 = symptom not present** **1 = mild** **2 = moderate** **3 = severe** **4 = very severe**

Symptom	**Frequency:**	**Severity:**
13. Fatigue / Extreme tiredness	0 1 2 3 4	0 1 2 3 4
14. Dead, heavy feeling after starting to exercise	0 1 2 3 4	0 1 2 3 4
15. Next-day soreness or fatigue after non-strenuous, everyday activities	0 1 2 3 4	0 1 2 3 4
16. Mentally tired after the slightest effort	0 1 2 3 4	0 1 2 3 4
17. Minimum exercise makes you physically tired	0 1 2 3 4	0 1 2 3 4
18. Physically drained or sick after mild activity	0 1 2 3 4	0 1 2 3 4
19. Feeling unrefreshed after you wake up in the morning	0 1 2 3 4	0 1 2 3 4
20. Needing to nap daily	0 1 2 3 4	0 1 2 3 4
21. Problems falling asleep	0 1 2 3 4	0 1 2 3 4
22. Problems staying asleep	0 1 2 3 4	0 1 2 3 4
23. Waking up early in the morning (e.g., 3:00am)	0 1 2 3 4	0 1 2 3 4
24. Sleeping all day and staying awake all night	0 1 2 3 4	0 1 2 3 4
25. Pain or aching in your muscles	0 1 2 3 4	0 1 2 3 4
26. Pain, stiffness, or tenderness in more than one joint, without swelling or redness	0 1 2 3 4	0 1 2 3 4
27. Eye pain	0 1 2 3 4	0 1 2 3 4
28. Chest pain	0 1 2 3 4	0 1 2 3 4
29. Bloating	0 1 2 3 4	0 1 2 3 4
30. Abdomen / Stomach pain	0 1 2 3 4	0 1 2 3 4

For each symptom below, please circle **one number for frequency** and **one number for severity**:

Frequency:	*Severity:*
Throughout the **past 6 months**, **how often** have you had this symptom? For each symptom listed below, circle a number from: **0 = none of the time** **1 = a little of the time** **2 = about half the time** **3 = most of the time** **4 = all of the time**	Throughout the **past 6 months**, **how much** has this symptom bothered you? For each symptom listed below, circle a number from: **0 = symptom not present** **1 = mild** **2 = moderate** **3 = severe** **4 = very severe**

Symptom	**Frequency:**	**Severity:**
31. Headaches	0 1 2 3 4	0 1 2 3 4
32. Muscle twitches	0 1 2 3 4	0 1 2 3 4
33. Muscle weakness	0 1 2 3 4	0 1 2 3 4
34. Sensitivity to noise	0 1 2 3 4	0 1 2 3 4
35. Sensitivity to bright lights	0 1 2 3 4	0 1 2 3 4
36. Problems remembering things	0 1 2 3 4	0 1 2 3 4
37. Difficulty paying attention for a long period of time	0 1 2 3 4	0 1 2 3 4
38. Difficulty finding the right word to say, or expressing thoughts	0 1 2 3 4	0 1 2 3 4
39. Difficulty understanding things	0 1 2 3 4	0 1 2 3 4
40. Only able to focus on one thing at a time	0 1 2 3 4	0 1 2 3 4
41. Unable to focus vision	0 1 2 3 4	0 1 2 3 4
42. Unable to focus attention	0 1 2 3 4	0 1 2 3 4
43. Loss of depth perception	0 1 2 3 4	0 1 2 3 4
44. Slowness of thought	0 1 2 3 4	0 1 2 3 4
45. Absent-mindedness or forgetfulness	0 1 2 3 4	0 1 2 3 4
46. Bladder problems	0 1 2 3 4	0 1 2 3 4
47. Irritable bowel problems	0 1 2 3 4	0 1 2 3 4
48. Nausea	0 1 2 3 4	0 1 2 3 4
49. Feeling unsteady on your feet, like you might fall	0 1 2 3 4	0 1 2 3 4

For each symptom below, please circle **one number for frequency** and **one number for severity**:

Frequency:	*Severity:*
Throughout the **past 6 months**, **how often** have you had this symptom?	Throughout the **past 6 months**, **how much** has this symptom bothered you?
For each symptom listed below, circle a number from: **0 = none of the time** **1 = a little of the time** **2 = about half the time** **3 = most of the time** **4 = all of the time**	For each symptom listed below, circle a number from: **0 = symptom not present** **1 = mild** **2 = moderate** **3 = severe** **4 = very severe**

Symptom	**Frequency:**	**Severity:**
50. Shortness of breath or trouble catching your breath	0 1 2 3 4	0 1 2 3 4
51. Dizziness or fainting	0 1 2 3 4	0 1 2 3 4
52. Irregular heart beats	0 1 2 3 4	0 1 2 3 4
53. Losing weight without trying	0 1 2 3 4	0 1 2 3 4
54. Gaining weight without trying	0 1 2 3 4	0 1 2 3 4
55. No appetite	0 1 2 3 4	0 1 2 3 4
56. Sweating hands	0 1 2 3 4	0 1 2 3 4
57. Night sweats	0 1 2 3 4	0 1 2 3 4
58. Cold limbs	0 1 2 3 4	0 1 2 3 4
59. Feeling chills or shivers	0 1 2 3 4	0 1 2 3 4
60. Feeling hot or cold for no reason	0 1 2 3 4	0 1 2 3 4
61. Feeling like you have a high temperature	0 1 2 3 4	0 1 2 3 4
62. Feeling like you have a low temperature	0 1 2 3 4	0 1 2 3 4
63. Alcohol intolerance	0 1 2 3 4	0 1 2 3 4

a. Over the last 6 months, did you avoid alcohol due to an alcohol intolerance (feeling sick after drinking alcohol?

□ Yes □ No, I drank alcohol □ No, I do not drink alcohol for other reasons

b. If you were to drink alcohol, how severe would the intolerance be?

□ Symptom Not Present □ Mild □ Moderate □ Severe □ Very Severe

For each symptom below, please circle **one number for frequency** and **one number for severity**:

Frequency:	*Severity:*
Throughout the **past 6 months**, **how often** have you had this symptom? For each symptom listed below, circle a number from: **0 = none of the time** **1 = a little of the time** **2 = about half the time** **3 = most of the time** **4 = all of the time**	Throughout the **past 6 months**, **how much** has this symptom bothered you? For each symptom listed below, circle a number from: **0 = symptom not present** **1 = mild** **2 = moderate** **3 = severe** **4 = very severe**

Symptom	**Frequency:**	**Severity:**
64. Sore throat	0 1 2 3 4	0 1 2 3 4
65. Tender / Sore lymph nodes	0 1 2 3 4	0 1 2 3 4
66. Fever	0 1 2 3 4	0 1 2 3 4
67. Flu-like symptoms	0 1 2 3 4	0 1 2 3 4
68. Some smells, foods, medications, or chemicals make you feel sick	0 1 2 3 4	0 1 2 3 4
69. Heart beats quickly after standing	0 1 2 3 4	0 1 2 3 4
70. Blurred or tunnel vision after standing	0 1 2 3 4	0 1 2 3 4
71. Graying or blacking out after standing	0 1 2 3 4	0 1 2 3 4
72. Sensitivity to mold	0 1 2 3 4	0 1 2 3 4
73. Intolerance to extremes of temperature	0 1 2 3 4	0 1 2 3 4
74. Viral infections with prolonged recovery periods	0 1 2 3 4	0 1 2 3 4
75. Muscle fatigue after mild physical activity	0 1 2 3 4	0 1 2 3 4
76. Worsening of symptoms after mild physical activity	0 1 2 3 4	0 1 2 3 4
77. Worsening of symptoms after mild mental activity	0 1 2 3 4	0 1 2 3 4
78. Feeling disoriented	0 1 2 3 4	0 1 2 3 4
79. Slowed speech	0 1 2 3 4	0 1 2 3 4
80. Difficulty reading (dyslexia) after mild physical or mental activity	0 1 2 3 4	0 1 2 3 4
81. Aching of the eyes or behind the eyes	0 1 2 3 4	0 1 2 3 4
82. Sensitivity to pain	0 1 2 3 4	0 1 2 3 4

For each symptom below, please circle **one number for frequency** and **one number for severity**:

Frequency:	*Severity:*
Throughout the **past 6 months**, **how often** have you had this symptom?	Throughout the **past 6 months**, **how much** has this symptom bothered you?
For each symptom listed below, circle a number from: **0 = none of the time** **1 = a little of the time** **2 = about half the time** **3 = most of the time** **4 = all of the time**	For each symptom listed below, circle a number from: **0 = symptom not present** **1 = mild** **2 = moderate** **3 = severe** **4 = very severe**

Symptom	**Frequency:**	**Severity:**
83. Pressure on parts of your body causes pain in other parts of your body	0 1 2 3 4	0 1 2 3 4
84. Daytime drowsiness	0 1 2 3 4	0 1 2 3 4
85. Sensitivity to vibration	0 1 2 3 4	0 1 2 3 4
86. Poor coordination	0 1 2 3 4	0 1 2 3 4
87. Sinus infections	0 1 2 3 4	0 1 2 3 4
88. Urinary urgency	0 1 2 3 4	0 1 2 3 4
89. Waking up at night because you need to urinate	0 1 2 3 4	0 1 2 3 4
90. Inability to tolerate an upright position	0 1 2 3 4	0 1 2 3 4
91. Fluctuations in temperature throughout the day	0 1 2 3 4	0 1 2 3 4

92. Have you **always** had persistent or recurring fatigue/energy problems, even back to your earliest memories as a child? (By persistent or recurring, we mean that the fatigue/energy problems are usually ongoing and constant, but sometimes there are good periods and bad periods.)

□ Yes □ No □ Not having a problem with fatigue/energy

93. Since your fatigue/energy related illness began, do your headaches either happen more often, feel worse or more severe, or are they in a different place or spot?

□ Yes □ No □ Not having a problem with fatigue/energy

94. How long ago did your problem with fatigue/energy begin?

- □ Less than 6 months
- □ 6-12 months
- □ 1-2 years
- □ Longer than 2 years
- □ Had problem with fatigue/energy since childhood or adolescence
- □ Not having a problem with fatigue/energy

95. Have you been diagnosed with Chronic Fatigue Syndrome or Myalgic Encephalomyelitis?

□ Yes □ No

a. In what year were you diagnosed?_____

b. Who diagnosed you with Chronic Fatigue Syndrome or Myalgic Encephalomyelitis?

□ Medical Doctor □ Alternative Practitioner □ Self-Diagnosed

96. Do you currently have a diagnosis of Chronic Fatigue Syndrome or Myalgic Encephalomyelitis?

□ Yes □ No

97. Have any of your family members been diagnosed with Chronic Fatigue Syndrome or Myalgic Encephalomyelitis?

□ Yes □ No

If yes, please list their relation to you and current age:

_____

_____

98. Did you experience any of the following symptoms regularly and repeatedly in the months and years before your fatigue/energy problems began?

- □ Sore throat
- □ Tender/sore lymph nodes
- □ Unrefreshing sleep
- □ Impaired memory and concentration
- □ Prolonged fatigue following physical or mental exertion
- □ Muscle pain
- □ Headaches
- □ Joint Pain
- □ Not having a problem with fatigue/energy

99. If you rest, does your problem with fatigue/energy go away? **(Check one)**

- □ Entirely
- □ Partially
- □ My fatigue/energy problem is not improved by rest *(Skip to Question 100)*
- □ I am not having a problem with fatigue/energy *(Skip to Question 100)*

a. How long do you have to rest for your problem with fatigue/energy to entirely or partially go away?

□ Fewer than 30 minutes □ 30 to 59 minutes □ 1-2 hours □ more than 2 hours

100. If you were to become exhausted after actively participating in extracurricular activities, sports, or outings with friends, would you recover within an hour or two after the activity ended?

□ Yes □ No

101. Do you reduce your activity level to avoid experiencing problems with fatigue/energy?

□ Yes □ No □ Not having a problem with fatigue/energy

102. Do you experience a worsening of your fatigue/energy related illness after engaging in minimal physical effort?

□ Yes □ No □ Not having a problem with fatigue/energy

103. Do you experience a worsening of your fatigue/energy related illness after engaging in mental effort?

□ Yes □ No □ Not having a problem with fatigue/energy

a. If you feel worse after physical or mental activity, how long does this last?

□ 1 hour or less □ 2-3 hours □ 4-10 hours □ 11-13 hours

□ 14-23 hours □ More than 24 hours (Please specify_____)

104. Are you currently engaging in any form of exercise?

□ Yes □ No

a. If you do not exercise, why aren't you exercising? Check all that apply.

□ Not interested

□ No time

□ Would like to but cannot because of problems with fatigue/energy

□ Cannot because exercise makes symptoms worse

105. If you were to engage in exercise or vigorous activity, would you feel physically drained or sick?

□ Yes □ No

106. Over what period of time did your fatigue/energy related illness develop?

- □ Within 24 hours
- □ Over 1 week
- □ Over 1 month
- □ Over 2-6 months
- □ Over 7-12 months
- □ Over 1-2 years
- □ Over 3 or more years
- □ I am not ill

107. How would you describe the course of your fatigue/energy related illness?

- □ Constantly getting worse
- □ Constantly improving
- □ Persisting (no change)
- □ Relapsing & remitting (having "good" periods with no symptoms & "bad" periods)
- □ Fluctuating (symptoms periodically get better and get worse, but never disappear completely)
- □ No Symptoms/I am not ill

108. Which statement best describes your fatigue/energy related illness during the **last 6 months**?

- □ I am not able to work or do anything, and I am bedridden
- □ I can walk around the house, but I cannot do light housework
- □ I can do light housework, but I cannot work part-time
- □ I can only work part time at work, or on some family responsibilities
- □ I can work full time, but I have no energy left for anything else
- □ I can work full time and finish some family responsibilities, but I have no energy left for anything else
- □ I can do all work or family responsibilities without any problems with my energy

109. Since the onset of your fatigue/energy related illness, have you stopped getting sick with colds or flus?

- □ Yes, I have stopped getting sick with colds or flus
- □ No, I still get sick with colds or flus
- □ I am unsure if there has been a change in whether I get colds or flus
- □ I do not have a fatigue/energy related illness

110. Did your fatigue/energy related illness start after you experienced any of the following? (Check one or more and please specify)

- □ An infectious illness_____
- □ An accident_____
- □ A trip or vacation_____
- □ An immunization (shot at doctor's office)_____
- □ Surgery_____
- □ Severe stress (bad or unhappy event(s))_____
- □ Other_____
- □ I am not ill

111. Have you ever consulted a medical doctor or health professional about your fatigue/energy problem?

□ Yes □ No

112. Do you currently have a medical doctor overseeing your fatigue/energy problem?

□ Yes □ No

113. Do you have any medical illness(es) that might be causing your symptoms?

□ Yes □ No

a. What medical illness(es) do you have? Illness name(s) and year it began:

_____

_____

_____

b. For which of these conditions are you currently receiving treatment?

_____

_____

_____

114. Are you currently taking any medications (over the counter or prescription)?

□ Yes □ No

a. What medications are you taking?

_____

_____

_____

115. Do you think any medication(s) is (are) causing your problem with fatigue/energy?

□ Yes □ No

□ I do not have a problem with fatigue/energy

a. Please specify which medications:_____

_____

116. Have you ever been diagnosed and/or treated for any of the following: (Check all that apply and write year(s) experienced, year(s) treated, and medication, if applicable, in the blank)

☐ Major depressive disorder

_____

☐ Major depressive disorder with melancholic or psychotic features

_____

☐ Bipolar disorder (manic-depression)

_____

☐ Anxiety

_____

☐ Schizophrenia

_____

☐ Eating disorder

_____

☐ Substance abuse

_____

☐ Multiple chemical sensitivities

_____

☐ Fibromyalgia

_____

☐ Allergies

_____

☐ Other (*Please specify*)

_____

☐ No diagnosis/treatment

117. What do you think is the cause of your problem with fatigue/energy? (Check one)

- □ Definitely physical
- □ Mainly physical
- □ Equally physical and psychological
- □ Mainly psychological
- □ Definitely psychological
- □ No problem with fatigue/energy

118. Do you think anything specific in your personal life or environment accounts for your problem with fatigue/energy?

- □ Yes □ No
- □ I do not have a problem with fatigue/energy

a. Please specify:_____

119. In the **past 4 weeks**, approximately how many **hours per week** have you spent doing:

Household related activities?_____hours per week

Social/Recreational related activities?_____hours per week

Family related activities?_____hours per week

Work related activities?_____hours per week

120. In the **past 4 weeks**, have you had to reduce the number of hours you previously spent (prior to your illness) on occupational, social or family activities because of your health or problems with fatigue/energy?

□ Yes □ No □ Not having a problem with fatigue/energy

a. **Before your fatigue/energy related illness**, approximately how many hours did you used to spend on:

Household related activities? _____hours per week

Social/Recreational related activities? _____hours per week

Family related activities? _____hours per week

Work related activities?_____hours per week

121. Please rate the amount of **energy** you had **available yesterday**, using a scale from 1 to 100 where 1= no energy and 100 = your pre-illness energy level. *(If you don't have a fatigue/energy related illness, a score of 100 = having abundant energy such that you could work full time and complete your family responsibilities)*:_____

122. Please rate the amount of **energy** you **expended** (used) **yesterday**, using a scale from 1 to 100 where 1 = no energy and 100 = your pre-illness energy expended: _____

123. Please rate the amount of **fatigue** you had **yesterday**, using a scale from 1 to 100 where 1 = no fatigue and 100 = severe fatigue: _____

124. For the **past week**, please rate the amount of **energy** you had **available** using a scale from 1 to 100 where 1 = no energy and 100 = your pre-illness energy level: _____

125. For the **past week**, please rate the amount of **energy** you have **expended** (used) using a scale from 1 to 100 where 1 = no energy and 100 = your pre-illness energy expended: _____

126. For the **past week**, please rate the amount of **fatigue** you have had using a scale from 1 to 100 where 1 = no fatigue and 100 = severe fatigue: _____

127. Since the onset of your problems with fatigue/energy, have your symptoms caused a 50% or greater reduction in your activity level?

□ Yes □ No □ Not having a problem with fatigue/energy

128. Do you experience frequent viral infections with prolonged recovery periods?

□ Yes □ No

129. Are you intolerant of extremes of temperatures (when it is extremely hot or cold)?

□ Yes □ No

To Measure Substantial Reduction Requirement in the Case Definitions

MOS SURVEY (SF-36)

INSTRUCTIONS:

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is: ***(Please circle one)***

   Excellent 1
   Very good 2
   Good 3
   Fair 4
   Poor 5

2. **Compared to one year ago,** how would you rate your health in general now? ***(Please circle one)***

   Much better than one year ago 1
   Somewhat better now than one year ago 2
   About the same as one year ago 3
   Somewhat worse now than one year ago 4
   Much worse now than one year ago 5

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

Activities	**Yes, Limited A Lot**	**Yes, Limited A Little**	**No, Not Limited At All**
Vigorous activities: running, lifting heavy objects, participating in strenuous sports	1	2	3
Moderate activities: moving a table, pushing a vacuum cleaner, bowling, playing golf	1	2	3
Lifting or carrying groceries	1	2	3
Climbing **several** flights of stairs	1	2	3
Climbing **one** flight of stairs	1	2	3
Bending, kneeling, or stooping	1	2	3
Walking **more than a mile**	1	2	3
Walking **several blocks**	1	2	3
Walking **one** block	1	2	3
Bathing or dressing yourself	1	2	3

4. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities as a result of your **physical health**?

Problems	**Yes**	**No**
Cut down on the **amount of time** you spent on work or other activities	1	2
Accomplished less than you would like	1	2
Were limited in the **kind** of work or other activities	1	2
Had **difficulty** performing the work or other activities (For example, it took extra effort)	1	2

5. During the **past 4 weeks**, have you had any of the following problems with your work or other

regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

Problems	Yes	No
Cut down the **amount of time** you spent on work or other activities	1	2
Accomplished less than you would like	1	2
Didn't do work or other activities as **carefully** as usual	1	2

6. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, neighbors, or groups? ***(Please circle one)***

Not at all 1
Slightly 2
Moderately 3
Quite a bit 4
Extremely 5

7. How much bodily pain have you had during the **past 4 weeks**?

None 1
Very mild 2
Mild 3
Moderate 4
Severe 5
Very Severe 6

8. During the **past 4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all 1
Slightly 2
Moderately 3
Quite a bit 4
Extremely 5

9. These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time **during the past 4 weeks**-

Questions	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
Did you feel full of pep?	1	2	3	4	5	6
Have you been a nervous person?	1	2	3	4	5	6
Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
Have you felt calm and peaceful?	1	2	3	4	5	6
Did you have a lot of energy?	1	2	3	4	5	6
Have you felt down-hearted and blue?	1	2	3	4	5	6
Did you feel worn out?	1	2	3	4	5	6
Have you been a happy person?	1	2	3	4	5	6
Did you feel tired?	1	2	3	4	5	6

10. During the **past 4 weeks**, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time 1

Most of the time..... 2
Some of the time..... 3
A little of the time..... 4
None of the time..... 5

11. How **TRUE** or **FALSE** is each of following statements for you?

Statements	**Definitely True**	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
I seem to get sick a little easier than other people	1	2	3	4	5
I am as healthy as anybody I know	1	2	3	4	5
I expect my health to get worse	1	2	3	4	5
My health is excellent	1	2	3	4	5