

**Pain and Fatigue Study Center
Healthy Research Candidate Questionnaire**

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Please note that all answers will be kept confidential.

Download, complete this form, and then FAX it to (212) 844-8545 or email it to dvu@bethisraelny.org.

Name: _____ Today's date: _____
Address: _____ Home phone: _____
_____ Work phone: _____
_____ Mobile phone: _____
E-mail _____ Date of birth _____

What is your Height? _____ Weight ? _____ Age ? _____ Sex ? _____

What is your culture? Hispanic Non-Hispanic

What is your race? White
 Black/African American
 Asian
 American Indian or Native Alaskan
 Native Hawaiian or other Pacific Islander
 Other, mixed or unknown

Employment status (check one)
 Full Time
 Part Time
 Unemployed, looking for work
 Unemployed due to health
 Retired (for any reason)
 Never worked outside home
 Other, please specify

Marital Status (check one)
 Married
 Divorced
 Never Married
 Widowed
 Separated
 Living as Married

1. Have you had any illness, other than colds or the flu, in the past five years? Yes No

If yes, please indicate the name of the illness, how long the illness lasted, and whether you currently have any symptoms:

2. Are you currently under a doctor's care? Yes No

If yes, please indicate why: _____

3. Have you ever had trauma or injury to your head which resulted in loss of consciousness? Yes
 No

If yes, how long were you unconscious? _____
Minutes? Hours? Healthy Days?

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? _____

At the time of the trauma or head injury did you feel dazed? Yes No
disoriented? Yes No
confused? Yes No

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

4. Are you currently taking any proscription medication, other than birth control pills?
 Yes No

If yes, please provide medication names and dosages:

5. Please rate your health: Excellent Good Fair Poor.

If not excellent, please explain: _____.

6. **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 7)**

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 |

7. 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 |

8. Have you ever had a fatiguing illness, such as mono, which lasted more than two weeks? Yes No

If yes, what caused the fatigue? _____

If yes, how long did the fatigue last? _____

9. Have you had a problem with alcohol or recreational drug use in the past 2 years? Yes No

In the past 2 years, did you ever need to make an effort to cut down on alcohol or drug use?

Yes No

In the past 2 years, did you ever have to give up or reduce important social or work activities because of alcohol or drug use? Yes No

In the past 2 years, were you ever annoyed by someone's criticism of your drinking or recreational drug use? Yes No

In the past 2 years, did the use of alcohol or other substances ever interfere with your relationship with family or friends? Yes No

10. Over the past 2 years, has there a period of time when you were feeling depressed or down most of the day nearly every day? Yes No

Over the past 2 years, were you less interested in most things or unable to enjoy the things you used to enjoy? Yes No

11. 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)? _____

12. Over the past 2 years, were you treated for an eating disorder? Yes No

13. Over the past 2 years, have you ever had a panic attack? That is, when you suddenly felt frightened, anxious, or extremely uncomfortable: usually accompanied by rapid breathing, palpitations, and sweating?
 Yes No

If yes, give details, including when it happened. _____

Have you ever had 4 attacks like that in a four-week period? Yes No

14. If female, are you currently pregnant or breast-feeding? Yes No

15. When is the last time you exercised on a regular basis, that is, at least once per week? _____

If you currently exercise, what type of exercise are you doing and how long does each session last?

16. Rate the degree to which you have had the following symptoms ***IN THE PAST MONTH?***
(0 = Never a problem, 1 = a mild problem, 2 = a moderate problem, 3 = a substantial problem, 4 = a severe problem and 5 = a very severe problem)

| | <i>In the past month</i> (circle one) | | | | | |
|--|---------------------------------------|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 |
| Feeling feverish..... | 0 | 1 | 2 | 3 | 4 | 5 |
| Chills | 0 | 1 | 2 | 3 | 4 | 5 |
| (If so, are the chills a teeth-chattering type? ___ yes ___no) | | | | | | |
| 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..... | 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 | 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 |
| Concentration problems | 0 | 1 | 2 | 3 | 4 | 5 |
| Fatigue | 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 |

16. If you do have **fatigue**, to what degree has it reduced your OCCUPATIONAL, EDUCATIONAL, SOCIAL OR PERSONAL **ACTIVITY LEVELS** (where 0 is not at all, 3 is substantially, and 5 is severely)
..... 0 1 2 3 4 5

17. What is the best way to reach you?

Phone

Home _____
time & day

Work _____
time & day

Mobile _____
time & day