

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

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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 _____ 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]

Circle EACH of the areas below that have been painful in the 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 **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.)

	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.....

	NO	YES	DON'T 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. 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 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)? _____

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

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

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

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

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

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

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>	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.			

1. Please rate the current (i.e., last week) **SEVERITY** of your sleeping problem(s).

	<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	<u>Very Severe</u>
Difficulty falling asleep:	0	1	2	3	4
Difficulty staying asleep:	0	1	2	3	4
Problem waking up too early:	0	1	2	3	4

2. How **SATISFIED**/dissatisfied are you with your current sleep pattern?

<u>Very Satisfied</u>					<u>Very Dissatisfied</u>
0	1	2	3	4	

3. 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.).

<u>Not at all Interfering</u>	<u>A Little</u>	<u>Somewhat</u>	<u>Much</u>	<u>Very Much Interfering</u>
0	1	2	3	4

4. How **NOTICEABLE** to others do you think your sleeping problem is in terms of impairing the quality of your life?

<u>Not at all Noticeable</u>	<u>Barely</u>	<u>Somewhat</u>	<u>Much</u>	<u>Very much Noticeable</u>
0	1	2	3	4

5. How **WORRIED**/distressed are you about your current sleep problem?

<u>Not at all</u>	<u>A Little</u>	<u>Somewhat</u>	<u>Much</u>	<u>Very Much</u>
0	1	2	3	4

**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					

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. 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
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