

DePaul Symptom Questionnaire – Short Form
DSQ – SF

For each symptom below, please circle **one number for frequency** and **one number for severity**:
Please complete the chart from left to right.

<i>Frequency:</i>	<i>Severity:</i>
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:
1. Fatigue/extreme tiredness	0 1 2 3 4	0 1 2 3 4
2. Next day soreness or fatigue after non-strenuous, everyday activities	0 1 2 3 4	0 1 2 3 4
3. Minimum exercise makes you physically tired	0 1 2 3 4	0 1 2 3 4
4. Feeling unrefreshed after you wake up in the morning	0 1 2 3 4	0 1 2 3 4
5. Pain or aching in your muscles	0 1 2 3 4	0 1 2 3 4
6. Bloating	0 1 2 3 4	0 1 2 3 4
7. Problems remembering things	0 1 2 3 4	0 1 2 3 4
8. Difficulty paying attention for a long period of time	0 1 2 3 4	0 1 2 3 4
9. Irritable bowel problems	0 1 2 3 4	0 1 2 3 4
10. Feeling unsteady on your feet, like you might fall	0 1 2 3 4	0 1 2 3 4
11. Cold limbs (e.g. arms, legs, hands)	0 1 2 3 4	0 1 2 3 4
12. Feeling hot or cold for no reason	0 1 2 3 4	0 1 2 3 4
13. Flu-like symptoms	0 1 2 3 4	0 1 2 3 4
14. Some smells, foods, medications, or chemicals make you feel sick	0 1 2 3 4	0 1 2 3 4

**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?

<u>Activities</u>	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**?

<u>Problems</u>	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?

<u>Statements</u>	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