Energy for life

FATIGUE

WEEKLY QUESTIONNAIRE FOR THE PATIENT

(Please return this questionaire to your therapist)

Naam: _____ **Datum:** ___ /___ /_____

Throughout our lives, most of us have times when we feel very tired or fatigued. Have you felt unusually tired or fatigued in the last week? ☐ Yes ☐ No

Please rate your fatigue (weariness, tiredness) by circling/marking the one number that best describes your fatigue right **NOW**.

0 1 2 3 4 5 6 7 8 9 10
No fatigue — As bad as you can imagine

Please rate your fatigue (weariness, tiredness) by circling/marking the one number that best describes your **USUAL** level of fatigue during past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No fatigue — As bad as you can imagine

Please rate your fatigue (weariness, tiredness) by circling/marking the one number that best describes your **WORST** level of fatigue during past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No fatigue — As bad as you can imagine

Circle/mark the one number that describes how, during the past 24 hours, **FATIQUE** has **INTERFERED** your:

- General activity

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

- Mood

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

- Walkin ability

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

- Normal work (includes both the home and daily chores)

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

- Rations with other people

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

- Enjoy of life

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes