Fatigue Questionnaire (Adult)

Patient ID __ __ - __ __ __ __ - __ __ __

Date of Evaluation: ___ / ___ / _____

Protocol timepoint *(see codes)*: _____

Instructions: This questionnaire captures symptoms of fatigue and the experience and impact fatigue has on daily activities. For each statement or question, mark one box.

Form completed by *(check all that apply)*:
☐ Patient ☐ Coordinator ☐ Interpreter
☐ Family member/friend ☐ Other

In the past 7 days…

	Never	Rarely	Sometimes	Often	Always
1. How often did you feel tired?	☐	☐	☐	☐	☐
2. How often did you experience extreme exhaustion?	☐	☐	☐	☐	☐
3. How often did you run out of energy?	☐	☐	☐	☐	☐
4. How often did your fatigue limit you at work (include work at home)?	☐	☐	☐	☐	☐
5. How often were you too tired to think clearly?	☐	☐	☐	☐	☐
6. How often were you too tired to take a bath or shower?	☐	☐	☐	☐	☐
7. How often did you have enough energy to exercise strenuously?	☐	☐	☐	☐	☐

Thank you for completing this questionnaire!