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

SYMPTOM ASSESSMENT

Instructions: This questionnaire asks how you are feeling and about symptoms you may be having. For each question, circle the number that best indicates how you feel.

1. Please record today's date ____ / ____ / _____
   month day year

2. Mark with an "|" the place on the line below that best indicates how you feel overall.

	Very good	Awful
Overall		

3. Mark each line with an "I" that best describes how you have felt **during the past week**. Place an "|" on each line below. { ---------|--------------}

	None	Worst ever
Fatigue		
Headaches		
Muscle/joint aches or pains		
Irritability		
Depression/sadness		

FOR CLINICAL COORDINATOR USE ONLY

Time point:

- ☐ Screen 2
- TMT Day ______ (7, 14, or 28)
- TMT Week ______ (8, 12, 16, 20, 24, 28, 32, 36, 40, 44, or 48)
- Follow-Up Week ______ (4, 12, 24, or 48)
- ☐ Premature discontinuation of treatment
- ☐ Premature discontinuation of follow-up

COMPLETION LOG

Data Collector ID _____________
Initials

Data Collection __ __ - __ __ - __ __

Date Entered __ __ - __ __ - __ __

Date Verified __ __ - __ __ - __ __
MM DD YY

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