Name (or ID): _____ Date: _____/_____/_____

SYMPTOMS. **During the past 2 weeks**, how much have you been **bothered** by any of the following?

| **Rate "bother" for the past 2 weeks** | Not at all | A little bit | Somewhat | Quite a bit | Very much |
|---|---|---|---|---|---|
| 1. Shortness of breath | 0 | 1 | 2 | 3 | 4 |
| 2. Feeling feverish | 0 | 1 | 2 | 3 | 4 |
| 3. Sweats and/or chills | 0 | 1 | 2 | 3 | 4 |
| 4. Nausea and/or vomiting | 0 | 1 | 2 | 3 | 4 |
| 5. Back pain | 0 | 1 | 2 | 3 | 4 |
| 6. Headaches | 0 | 1 | 2 | 3 | 4 |
| 7. Stiff or painful neck | 0 | 1 | 2 | 3 | 4 |
| 8. Muscle aches or pains | 0 | 1 | 2 | 3 | 4 |
| 9. Joint pain or swelling | 0 | 1 | 2 | 3 | 4 |
| 10. Muscle weakness | 0 | 1 | 2 | 3 | 4 |
| 11. Feeling fatigued or having low energy | 0 | 1 | 2 | 3 | 4 |
| 12. Feeling worse after normal physical exertion | 0 | 1 | 2 | 3 | 4 |
| 13. Trouble falling asleep or staying asleep | 0 | 1 | 2 | 3 | 4 |
| 14. Needing more sleep than usual | 0 | 1 | 2 | 3 | 4 |
| 15. Not feeling rested on awakening | 0 | 1 | 2 | 3 | 4 |
| 16. Numbness or tingling | 0 | 1 | 2 | 3 | 4 |
| 17. Shooting, stabbing, or burning pains | 0 | 1 | 2 | 3 | 4 |
| 18. Skin or muscle twitching | 0 | 1 | 2 | 3 | 4 |
| 19. Discomfort with normal light or sound | 0 | 1 | 2 | 3 | 4 |
| 20. Balance problems or sense of room-spinning | 0 | 1 | 2 | 3 | 4 |
| 21. Change in visual clarity or trouble focusing | 0 | 1 | 2 | 3 | 4 |
| 22. Bladder discomfort or change in urination | 0 | 1 | 2 | 3 | 4 |
| 23. Light-headed or uncomfortable on standing | 0 | 1 | 2 | 3 | 4 |
| 24. Hot or cold sensations in extremities | 0 | 1 | 2 | 3 | 4 |
| 25. Irregular or rapid heart beats | 0 | 1 | 2 | 3 | 4 |
| 26. Feeling irritable, sad, or decreased pleasure | 0 | 1 | 2 | 3 | 4 |
| 27. Feeling panicky, anxious, or worried | 0 | 1 | 2 | 3 | 4 |
| 28. Trouble finding words or retrieving names | 0 | 1 | 2 | 3 | 4 |
| 29. Trouble with memory | 0 | 1 | 2 | 3 | 4 |
| 30. Slower speed of thinking | 0 | 1 | 2 | 3 | 4 |

**Over the last 2 weeks, have any of the above impaired your work, social, or family functioning?** Yes No

**If Yes**, please indicate the row number of each of the most impairing symptoms below, **starting with the most impairing (#1)**, then list the next most impairing (#2), and continue listing in descending severity other impairing symptoms.

1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____