FIBROQUEST QUESTIONNAIRE

Answer each question in view of your symptoms over the past month, regardless of the length of time you have experienced the symptoms. If you're not certain about how to answer a particular question, give the answer or pick the option that seems more correct than the others. Please feel free to write additional comments.

Name:_____Today's Date:_____
Birth Date:_____ Street Address:_____
City:_____ State:_____ Zip:_____ Home Phone:_____
Work Phone:_____ Cell Phone:_____ E-mail address:_____
Occupation:_____ Domestic status:_____
Did you stop working because of your main complaint? ☐ Yes ☐ No If yes, how long ago did you stop working? _____ How do you spend most of your day?

☐ standing ☐ walking ☐ sitting ☐ lying ☐ lifting
☐ typing ☐ using phone ☐ computer work ☐ driving ☐ other:_____

Your ***main*** symptom?_____ When did it begin?_____
What was the initial cause?_____ What worsens the symptom?_____
_____ _____ What improves it ?_____
Is it getting worse?_____ Does it interfere with your: ☐ work ☐ sleep ☐ recreational or leisure activities ☐ family or marital responsibilities ☐ other aspects of your life? (Specify):_____
You suffer from this ☐ when you wake up ☐ later in the day _____% of your waking hours.

"Your main complaint." (Marking "0" means the symptom doesn't bother you. "10" is as severe as possible.)

0 1 2 3 4 5 6 7 8 9 10

Check the appropriate boxes: Are you pregnant? ☐ Yes ☐ No Do you wear a pacemaker. ☐ Yes ☐ No
Do you take anticoagulant drugs. ☐ Yes ☐ No List any drugs or food you're allergic to:_____
_____

Have you been diagnosed as having cancer? ☐ Yes ☐ No Do you have an adrenal problem ? ☐ Yes ☐ No
Do you have problems with blood circulation? ☐ Yes ☐ No Do you wear orthotics?_____
Do you have a heart problem ? ☐ Yes ☐ No If you are sexually active, are there any problems?_____

If you smoke tobacco, how many packs per day?___ If you drink alcoholic beverages, about how much and how often?_____ Do you use caffeine tablets such as NoDoz or Vivarin?_____ If so, how much and how often?_____ Do you live alone or with others?_____ Do you find this ☐ satisfactory ☐ unsatisfactory.

List medical conditions (other accidents, illnesses, infections, pain, or disabilities) in the past l0 years:
Condition:_____ Approx. Date:_____
Condition:_____ Approx. Date:_____
Condition:_____ Approx. Date:_____
Condition:_____ Approx. Date:_____
Condition:_____ Approx. Date:_____

PREVIOUS TREATMENT

Please list the other health care providers you have seen for your present condition.
Name:_____ Type of Practitioner:_____ Date:_____
Name:_____ Type of Practitioner:_____ Date:_____
Name:_____ Type of Practitioner:_____ Date:_____
Name:_____ Type of Practitioner:_____ Date:_____

MEDICATIONS
List all medications you are presently (or have recently been) taking:

Current Medication	Dosage	Medication	Dosage

If you ever took oral contraceptives, for how long?_____ Are you still taking them? ☐ Yes ☐ No If not, when did you stop?_____ Do you still have menstrual periods? ☐ Yes ☐ No If no, check either of the following: (1) you became menopausal naturally ☐ (2) you had a hysterectomy ☐ (what year?): _____. If you still have menstrual periods, are they ☐ normal ☐ irregular ☐ painful ☐ short ☐ prolonged? Do you have ☐ heavy or ☐ light flow? Are you peri-menopausal? ☐ Yes ☐ No Please describe any form of female sex hormone replacement you use:_____

VITAMINS, MINERALS, & HERBS List any vitamins, mineral, and/or herbs you take:

Vitamin, Mineral, Herb	How often	Vitamin, Mineral, Herb	How Often

DIET Please describe your eating habits (time of day and foods you usually consume): _____
_____
_____
Are you vegetarian? ☐ Yes ☐ No Do you eat sugary foods each day? ☐ Yes ☐ No When you don't eat at regular intervals, do you feel (check all that apply) ☐ dizzy ☐ faint ☐ clammy ☐ headachy ☐ shaky ☐ pounding heart? Does eating relieve these feelings? ☐ Yes ☐ No What foods relieve the feelings?_____
_____

If you restrict your food intake for weight control, do you do so ☐ regularly or ☐ at intervals? About how many glasses of liquids do you drink each day?_____ Of the following caffeinated drinks, how many cups, cans, or bottles do you usually consume each day? coffee____ tea____ soft drinks ____. List any symptoms the caffeine improves: _____

PAIN Would you describe your pain as (check all that apply) ☐ mild ☐ moderate ☐ severe ☐ sharp ☐ dull ☐ burning ☐ aching ☐ throbbing ☐ having clear-cut boundaries (you could specifically outline its margins with your finger) or ☐ hazy boundaries (fades as it spreads from the most intense area)?

How intense has your pain been? (Marking "0" means you have no pain. "10" is as severe as possible.)
0 1 2 3 4 5 6 7 8 9 10

Comments:_____

How tired have you felt? ("0" means you have no fatigue. "10" means you have the worse fatigue possible.)
0 1 2 3 4 5 6 7 8 9 10

Comments:_____

STIFFNESS When you get up in the morning, you are ☐ not stiff ☐ mildly stiff ☐ moderately stiff ☐ severely stiff. It takes ____ hours and/or ____minutes to loosen up.
Describe:_____

How stiff have you felt? (Marking "0" means you haven't felt stiff. "10" means you've felt severely stiff.)

0 1 2 3 4 5 6 7 8 9 10

Comments:_____

HEADACHES How often?_____Please describe:_____

How intense have your headaches been? (Marking "0" means no headaches. "10" means as severe as possible.)

0 1 2 3 4 5 6 7 8 9 10

Comments:_____

SLEEP (check appropriate boxes) ☐ You have no trouble sleeping. ☐ You sometimes have trouble sleeping. ☐ You often have trouble sleeping. ☐ You always have insomnia. ☐ Your pain wakes you during the night. You usually wake up feeling: ☐ refreshed ☐ better ☐ as tired as when you went to bed ☐ mentally and physically sluggish. What position(s) do you usually sleep in? ☐ Face down ☐ On your back ☐ Left side ☐ Right side. How old is your mattress?_____

How disturbed has your sleep been? ("0" means you've had no sleep disturbance. "10" means severely disturbed.)

0 1 2 3 4 5 6 7 8 9 10

Comments:_____

STOMACH, INTESTINAL, AND URINARY SYSTEM	**Mild**	**Moderate**	**Severe**
You usually have: 1) diarrhea or watery stools:	☐	☐	☐
2) constipation (need to strain/hard stool):	☐	☐	☐
3) bloating (intestinal gas):	☐	☐	☐
4) abdominal cramps:	☐	☐	☐
5) abdominal pain:	☐	☐	☐

How many times do you usually urinate each day?_____

How disturbed has your bowel function been? ("0" means your bowel function is fine; "10," severely disturbed.)

0 1 2 3 4 5 6 7 8 9 10

Comments:_____

EMOTIONS (check appropriate boxes)
Most of the time lately you feel: ☐ happy ☐ relaxed ☐ worried ☐ depressed ☐ sad ☐ anxious ☐ contented ☐ enthusiastic ☐ irritable ☐ calm ☐ angry ☐ pleasant ☐ restless ☐ friendly

How depressed have you felt? (Marking "0" means no depression. "10" means the worse depression possible.)

0 1 2 3 4 5 6 7 8 9 10

Comments:_____

THINKING AND ATTENTION Do you have problems with ☐ memory ☐ concentration? Further description:_____

How bad have your concentration and/or memory been? ("0" means fine. "10" means as bad as possible.)
0 1 2 3 4 5 6 7 8 9 10

Comments:_____

ANXIETY If you're anxious, is it: ☐ often ☐ seldom ☐ brief ☐ long-lasting ☐ mild ☐ moderate ☐ severe

How anxious have you felt? (Marking "0" means no anxiety. "10" means the worse anxiety possible.)
0 1 2 3 4 5 6 7 8 9 10

Comments:_____

COLDNESS
Are you usually cold ☐ or hot ☐ when others around you are comfortable? Which body parts are too cold or hot? ☐ hands ☐ feet ☐ most of your body. Further description:_____

How cold have you felt? (Marking "0" means you haven't been too cold. "10" means severely cold.)
0 1 2 3 4 5 6 7 8 9 10

Comments:_____

ABNORMAL SENSATIONS
You have abnormal sensations (such as tingling or numbness) in your: ☐ hands ☐ feet ☐ other body parts:_____ Please describe your abnormal sensations:_____

How much numbness or tingling have you felt? (Marking "0" means none; "10," severe numbness or tingling.)
0 1 2 3 4 5 6 7 8 9 10

Comments:_____

DRYNESS Do you have dryness of your: ☐ eyes ☐ mouth ☐ hair ☐ other:_____

How dry have your mucous membranes, skin, or hair been? ("0" means not dry. "10" means the worst possible.)
0 1 2 3 4 5 6 7 8 9 10

Comments:_____

EXERCISE AND ACTIVITY You have trouble exercising. ☐ Yes ☐ No You have the energy and endurance you need to exercise. ☐ Yes ☐ No Your symptoms worsen after you exercise. ☐ Yes ☐ No Which symptoms worsen?____ _____ How long do the worsened symptoms last?_____
How many days per week do you engage in the following? 1) aerobic exercise:_____ Which aerobic activities you engage in: ☐ walking ☐ running ☐ aerobics ☐ other:_____
2) stretching:_____ Which type of stretching: ☐ yoga ☐ martial arts ☐ Others:_____
3) toning exercises: Which type: ☐ weights at a gym or home ☐ calisthenics ☐ Other:_____

How difficult has exercise been for you? (Marking "0" means exercise is not difficult. "10" means severe difficulty.)
0 1 2 3 4 5 6 7 8 9 10

Comments:_____