

Fatigue - Short Form 7b Daily

Please respond to each question or statement by marking one box per row.

Since you woke up today...

		Never	Rarely	Sometimes	Often	Always
FATEXP 20day	How often did you feel tired?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
FATEXP 5day	How often did you experience extreme exhaustion?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
FATEXP 18day	How often did you run out of energy?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
FATIMP 33day	How often did your fatigue limit you at work (include work at home)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
FATIMP 30day	How often were you too tired to think clearly?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
FATEXP 6day	How often did you feel tired even when you hadn't done anything?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
FATIMP 3day	How often did you have to push yourself to get things done because of your fatigue?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5