Patient Questionnaire

Name_____ Date_____

Presently, how would you score:

	None	mild	moderate		severe	
Fatigue	0	1	2	3	4	5
Trouble Sleeping	0	1	2	3	4	5
Difficulty concentrating	0	1	2	3	4	5
Restless legs	0	1	2	3	4	5
Change in taste	0	1	2	3	4	5
Loss of appetite	0	1	2	3	4	5
Nausea and/or vomiting	0	1	2	3	4	5
Itching	0	1	2	3	4	5
Bone pain	0	1	2	3	4	5
Muscle pain and/or weakness	0	1	2	3	4	5

Considering all parts of my life----physical, emotional, social, spiritual and financial,, during the past two days, the *quality of my life has been:*

Very bad excellent

0 1 2 3 4 5 6 7 8 9 10

During the past month, have you:

Had little interest or pleasure in doing things	yes	no
Felt down, depressed or hopeless	yes	no