FATIGUE QUESTIONNAIRE

Claimant Name:

SSN: Date:

1) Do you have a medical condition that causes you to experience fatigue, tiredness or low energy? ☐ Yes ☐ No

2) How long have you experienced the fatigue? _____

3) How does fatigue affect you and your daily activities? Explain.

4) How often do you experience fatigue? Every day or only sometimes? Explain:

5) Does your fatigue affect the following activities?

a) Shower/bathing and dressing ☐ Yes ☐ No

Explain: _____

b) Preparing meals ☐ Yes ☐ No

Explain: _____

c) Driving or using public transportation ☐ Yes ☐ No

Explain: _____

d) Visiting with friends ☐ Yes ☐ No

Explain: _____

e) Completing household chores and cleaning? ☐ Yes ☐ No

Explain: _____

6) How far can you walk before having to rest? _____

7) How long do you need to rest before resuming walking? _____

8) How many hours of sleep do you normally get in a 24-hour period? _____

9) How many times do you stop to rest during the day?

_____

10) Do you nap during the day? ☐ Yes ☐ No

a) How often and how long? _____

11) Do you have additional symptoms (for example, pain, weakness, lightheadedness)?

☐ Yes ☐ No If yes, describe.

12) If you have anything further to add about your fatigue, please include it here.

If you need more space, please attach additional page(s).

Name of person completing this form (Please print) | Date | Phone

Address | City | State | ZIP