This document will provide the basic information, forms, and charts that providers need to diagnose and initiate management of Chronic Fatigue Syndrome / Myalgic Encephalopathy (CFS/ME).

We recommend that providers divide the evaluation of CFS/ME into two or three visits:

**VISIT 1**
- History and physical
- Laboratory

**VISIT 2**
- Apply the case definition to confirm or refute diagnosis
- Education
- Initiate therapy

**VISIT 3**
- Follow-up
- Optional instruments

Simply print out each visit before seeing the patient.
Visit 1

Goal: Exclude other conditions that could explain the patient’s symptoms; then collect information that will make or refute the diagnosis of CFS/ME.

First, does the patient have the four cardinal symptoms of CFS/ME?

- Fatigue
  - a. While the patient may complain of sleepiness, reduced energy or stamina are the major complaints
  - b. Post-exertional malaise is present. That is, fatigue (malaise and sickness) lasts 24 hours or more following exertion.
  - c. Fatigue is severe enough that it has significantly impacted lifestyle and work.

- Pain is present
  - d. Myalgias or muscle pain and/or,
  - e. Arthralgias, usually migratory, not associated with swelling, heat, or redness, and/or
  - f. Headache of new onset or changed in severity.

- Sleep disruption
  - g. Disturbed sleep
  - h. Sleep is usually not refreshing

- Problems with cognition
  - i. Difficulty recalling familiar names or numbers, recent events or conversations.
  - j. Searching for words
  - k. Difficulty sequencing (e.g., do this, then that, then that; such as a recipe)
  - l. Difficulty focusing or concentrating
  - m. Difficulty comprehending (e.g. read the same paragraph several times)
  - n. Difficulty processing, maintaining, or expressing thoughts

If any of these symptoms are minimal or absent, the diagnosis of CFS/ME is in question. Consider a routine history and physical, and follow-up over time.

If the cardinal symptoms are present perform a physical examination, following the recommendations in CHART 1 below.

Obtain exclusionary laboratory studies to rule out other plausible causes for the patient's symptoms. Such studies might include:

- Complete blood count (CBC)
- Comprehensive Metabolic Panel (electrolytes, BUN, Cr, glucose, calcium, phosphorus, total protein, albumin, globulin, alkaline phosphatase, SGOT/ALT, SGPT/AST)
- C-reactive protein or Westergren sedimentation rate
- Thyroid function tests
  - o TSH is least important due to HPA Axis suppression in CFS/ME
  - o Free T4 plus total T3 or T3 Uptake
- Urinalysis
- ANA and Rheumatoid Factor, if indicated

Obtain any other laboratory studies indicated by your history and exam, such as:

- Cranial MRI if Multiple Sclerosis or other neurological disorder suspected
- Overnight sleep study (primary sleep disorders such as apnea and periodic leg movement syndrome occur in up to 60% of patients)
- Sjogren’s antibodies (SSA (Ro) /SSB (La) ) if dry eyes and mouth are present
- Lyme serology (ELISA) or Western Blot if patient has had tick exposure or comes from an endemic area (Northeast US, Wisconsin area, California and others)
- Hepatitis C serology if “at risk” or has had elevated liver function tests
- CPK if muscle tenderness is present and myositis is suspected
- Obtain consultation if a significant psychiatric condition is present or suspected
Chart 1  

**PATIENT ASSESSMENT**

NAME: ________________________________________  DATE: ___________________

<table>
<thead>
<tr>
<th>VITAL SIGNS</th>
</tr>
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<tbody>
<tr>
<td>Temp</td>
</tr>
<tr>
<td>Supine BP</td>
</tr>
</tbody>
</table>

**OBJECTIVE**

**Fundus:**

**Eyes:**

**ENT:** (Pharynx shallow or ample? Large tongue? TMJ tender?)

**Neck:** (Thyromegaly or carotidynia?)

**Lymph nodes:** (Tender and/or swollen cervical or axillary nodes?)

**Heart:**

**Lungs:**

**Abdomen:**

**Extremities:**

**Skin:** (Acne rosacea? Livido reticularis?)

**MUSCULOSKELETAL**

*Good tone? No atrophy?*

*Joint swelling, heat, or redness? Nodularity?*

*Nodularity at joints (  )*

*Range of motion normal? Hyperextensibility?*

*Tenderpoints of fibromyalgia present?*

*Myofascial bands present?*

**NEUROLOGICAL**

**Handedness:** ( ) Right ( ) Left ( ) Ambi

**Cranial nerves:**

**Finger-to-nose:** (Tremor? Dysmetria?)

**Random alternating movements:** (Dysdiadokinesia?)

**Balance:**

**Tandem stance:**

**Romberg:**

**DTRs:**

**Babinski reflexes:**

**Tinel’s and/or Phelan’s sign (optional)**

**Adson’s sign (optional)**

**Neurocognitive (Serial 7 Subtraction, Digit Span)**

**MENTAL STATUS**

**Affect:** (Normal? Anxious? Flat?)

**Speech:** (Normal? Halting? Rapid?)

**Fund of knowledge:** (Average? Above or below average?)

**Oriented to person, place, and time?:**

**Reality check:** (Any hallucinations or delusions?)

**Cyclothymia:** (Alternating depression/mania? Risky behaviors? Grandiosity?
- Decreased need for sleep? Racing thoughts? Pressured speech?)
VISIT 2

Goal: Use a standardized instrument to confirm (or refute) the diagnosis of CFS/ME; then provide the patient with resources and an initial treatment program.

First, use CHART 2 on page 6 (based on the 1994 CDC or International Criteria) or CHART 3 on page 7 (which is based on the 2003 Canadian Clinical Criteria) below to formally confirm or refute the diagnosis of CFS/ME.

If the patient DOES NOT meet either one of these criteria, treat her/him appropriately and re-evaluate periodically.

If the patient’s diagnosis is CONFOUNDED, treat the concurrent or confounding problems and re-evaluate periodically.

If the patient DOES meet either one of these criteria, provide her/him with the Patient Handout below (pages 8 & 9) and develop an initial treatment program.
Chart 2  INTERNATIONAL / CDC CFS CASE DEFINITION*

NAME: ___________________________________ DATE: ___________________

Step 1. **Exclude** alternative diagnoses and other causes of chronic fatigue.

- Alternative diagnoses and other likely causes of chronic fatigue have been excluded by history, physical examination, exclusionary laboratory tests, and mental status examination.
- There is no evidence of melancholic depression

Step 2. Does the patient have **chronic fatigue** that is both:

- A perception of diminished and finite energy that with usual or normal activity demands a substantial change in work or school and the usual lifestyle?
- New in onset (not lifelong) and has been persisting or relapsing for at least 6 months?

Step 3. Does the patient show **at least four classic symptoms**, which have been chronically or intermittently present for at least 6 months, make up a significant component of the illness, but have not predated the fatigue?

- The new onset of cognitive dysfunction characterized by short term memory loss; word searching or poor recall; diminished comprehension or oral or written information; new difficulty in processing, maintaining, or expressing thoughts; possibly difficulty with sequencing of events or numbers, or difficulty with simple math (making change, keeping up finances).
- Non-exudative pharyngitis. A non-exudative, “scratchy” or sore throat, frequent or relapsing in nature.
- Lymphodynia or lymphatic soreness in at least two sites: anterior cervical, posterior cervical, axillary, or inguinal.
- Muscle discomfort of a generalized nature. Flu-like myalgias or tenderness to touch (alldynia or “touch me not”).
- Joint discomfort (arthralgias) usually migratory and involving large joints more than small joints.
- Headaches of new onset or increased intensity, frequently retro-orbital or occipital and worsening with stress or exertion.
- Sleep is disturbed and/or non-restorative.

It is helpful to subcategorize your patient.

Onset of illness
- a. Abrupt onset over hours or days
- b. Gradual or insidious onset

Severity of symptoms (clinician's global impression)
- a. Minimal – some symptoms especially with effort. Usually able to work.
- b. Mild – mild symptoms and limitations, even at rest. May be able to work.
- c. Moderate – moderate symptoms at rest, worse with effort. Unable to work.
- d. Severe – often housebound or bedbound.

**FINAL CLINICAL IMPRESSION**

______ Patient meets criteria for Chronic Fatigue Syndrome (Step 1 + Step 2 + ≥ 4 symptoms)
______ CFS is probable or possible but confounded by a concurrent medical or psychiatric condition, or lacks sufficient criteria
______ Idiopathic chronic fatigue. CFS unlikely or excluded by ____________________________.

* Based on the international case definition criteria (Fukuda, et al. Annals of IM, 1994) and “A case definition for practitioners” (Lapp C, Annals of IM, 1995)
**CLINICAL WORKING CASE DEFINITION OF ME/CFS**

**Myalgic Encephalomyelitis/Chronic Fatigue Syndrome**

A patient with ME/CFS will meet the criteria for fatigue, post-exertional malaise and/or fatigue, sleep dysfunction, and pain; have two or more neurological/cognitive manifestations and one or more symptoms from two of the categories of autonomic, neuroendocrine, and immune manifestations; and adhere to item 7.

1. Fatigue: The patient must have a significant degree of new onset, unexplained, persistent, or recurrent physical and mental fatigue that substantially reduces activity level.

2. Post-Exertional Malaise and/or Fatigue: There is an inappropriate loss of physical and mental stamina, rapid muscular and cognitive fatigability, post exertional malaise and/or fatigue and/or pain and a tendency for other associated symptoms within the patient’s cluster of symptoms to worsen. There is a pathologically slow recovery period - usually 24 hours or longer.

3. Sleep Dysfunction: There is unresolved sleep or sleep quantity or rhythm disturbances such as revolved or chaotic diurnal sleep rhythm.

4. Pain: There is a significant degree of myalgia. Pain can be experienced in the muscles, and/or joints, and is often widespread and migratory in nature. Often there are significant headaches of new type, pattern or severity.

5. Neurological/Cognitive Manifestations: Two or more of the following difficulties should be present: confusion, impairment of concentration and short-term memory consolidation, disorientation, difficulty with information processing, categorizing and word retrieval, and perceptual and sensory disturbances - e.g. spatial instability and disorientation and inability to focus vision. Ataxia, muscle weakness and fasciculations are common. There may be overabundant phenomena: cognitive, sensory - e.g. photophobia and hypersensitivity to noise - and/or emotional overload, which may lead to "crash" periods and/or anxiety.

6. At Least One Symptom from Two of the Following Categories:
   a. Autonomic Manifestations: orthostatic intolerance - neurally mediated hypotension (NPH), postural orthostatic tachycardia syndrome (POSTS), delayed postural hypotension; light-headedness; extreme pallor; nausea and irritable bowel syndrome; urinary frequency and bladder dysfunction; palpitations with or without cardiac arrhythmias; exertional dyspnea.
   b. Neuroendocrine Manifestations: loss of hormonal stability - subnormal body temperature and marked diurnal fluctuation, sweating episodes, recurrent feelings of feverishness and cold extremities; intolerance of extremes of heat and cold; marked weight change - anorexia or abnormal appetite; loss of adaptability and worsening of symptoms with stress.
   c. Immune Manifestations: tender lymph nodes, recurrent sore throat, recurrent flu-like symptoms, general malaise, new sensitivities to food, medications and/or chemicals.

7. The illness persists for at least six months: It usually has a distinct onset. **Although it may be gradual.** Preliminary diagnosis may be possible earlier. Three months is appropriate for children.

Exclusions: Exclude active disease processes that explain most of the major symptoms of fatigue, sleep disturbance, pain, and cognitive dysfunction. It is essential to exclude certain diseases, which would be tragic to miss: Addison’s disease, Cushing’s Syndrome, hypothyroidism, hypothyroidism, iron deficiency, other treatable forms of anemia, iron overload syndrome, diabetes mellitus, and cancer. It is also essential to exclude treatable sleep disorders such as upper airway resistance syndrome and obstructive or central sleep apnea; rheumatological disorders such as rheumatoid arthritis, lupus,

Patient Handout

Chronic Fatigue Syndrome / Myalgic Encephalopathy  (CFS/ME)

Chronic fatigue syndrome, or CFS, is a debilitating and complex disorder characterized by profound fatigue that is not improved by bed rest and that may be worsened by physical or mental activity. Persons with CFS most often function at a substantially lower level of activity than they were capable of before the onset of illness. In addition to these key defining characteristics, patients report various nonspecific symptoms, including weakness, muscle pain, impaired memory and/or mental concentration, insomnia, and post-exertional fatigue lasting more than 24 hours. In some cases, CFS can persist for years. The cause or causes of CFS have not been identified and no specific diagnostic tests are available. Moreover, since many illnesses have incapacitating fatigue as a symptom, care must be taken to exclude other known and often treatable conditions before a diagnosis of CFS is made.

Similar Medical Conditions
A number of illnesses have been described that have a similar spectrum of symptoms to CFS. These include fibromyalgia syndrome, myalgic encephalomyelitis, neurasthenia, multiple chemical sensitivities, and chronic mononucleosis. Although these illnesses may present with a primary symptom other than fatigue, chronic fatigue is commonly associated with all of them.

Other Conditions That May Cause Similar Symptoms
In addition, there are a large number of clinically defined, frequently treatable illnesses that can result in fatigue. Diagnosis of any of these conditions would exclude a definition of CFS unless the condition has been treated sufficiently and no longer explains the fatigue and other symptoms. These include hypothyroidism, sleep apnea and narcolepsy, major depressive disorders, chronic mononucleosis, bipolar affective disorders, schizophrenia, eating disorders, cancer, autoimmune disease, hormonal disorders, subacute infections, obesity, alcohol or substance abuse, and reactions to prescribed medications.

Other Commonly Observed Symptoms in CFS
In addition to the eight primary defining symptoms of CFS, a number of other symptoms have been reported by some CFS patients. The frequencies of occurrence of these symptoms vary from 20% to 50% among CFS patients. They include abdominal pain, alcohol intolerance, bloating, chest pain, chronic cough, diarrhea, dizziness, dry eyes or mouth, earaches, irregular heartbeat, jaw pain, morning stiffness, nausea, night sweats, psychological problems (depression, irritability, anxiety, panic attacks), shortness of breath, skin sensations, tingling sensations, and weight loss.

Prevalence of CFS
Chronic fatigue syndrome (CFS) affects more than one million people in the United States. There are tens of millions of people with similar fatiguing illnesses who do not fully meet the strict research definition of CFS.

Risk Factors for CFS
People of every age, gender, ethnicity and socioeconomic group can have CFS. CFS affects women at four times the rate of men. Research indicates that CFS is most common in people in their 40s and 50s. Although CFS is much less common in children than in adults, children can develop the illness, particularly during the teen years.

Defining CFS Symptoms
CFS is marked by extreme fatigue that has lasted at least six months; is not the result of ongoing effort; is not substantially relieved by rest; and causes a substantial reduction in daily activities. In addition to fatigue, CFS includes eight characteristic symptoms: postexertional malaise (relapse of symptoms after physical or mental exertion); unrefreshing sleep; substantial impairment in memory/concentration; muscle pain;
pain in multiple joints; 
headaches of a new type, pattern or severity; 
sore throat; and 
tender neck or armpit lymph nodes.

Symptoms and their consequences can be severe. CFS can be as disabling as multiple sclerosis, lupus, rheumatoid arthritis, congestive heart failure and similar chronic conditions. Symptom severity varies from patient to patient and may vary over time for an individual patient.

**Diagnosis of CFS**

There are no physical signs that identify CFS. There are no diagnostic laboratory tests for CFS. People who suffer the symptoms of CFS must be carefully evaluated by a physician because many treatable medical and psychiatric conditions are hard to distinguish from CFS. Common conditions that should be ruled out through a careful medical history and appropriate testing include mononucleosis, Lyme disease, thyroid conditions, diabetes, multiple sclerosis, various cancers, depression and bipolar disorder.

Research conducted by the Centers for Disease Control and Prevention (CDC) indicates that less than 20% of CFS patients in this country have been diagnosed.

**Treatment of CFS**

Since there is no known cure for CFS, treatment is aimed at symptom relief and improved function. A combination of drug and nondrug therapies is usually recommended.

No single therapy exists that helps all CFS patients. Lifestyle changes, including prevention of overexertion, reduced stress, dietary restrictions, gentle stretching and nutritional supplementation, are frequently recommended in addition to drug therapies used to treat sleep, pain and other specific symptoms. Carefully supervised physical therapy may also be part of treatment for CFS. However, symptoms can be exacerbated by overly ambitious physical activity. A very moderate approach to exercise and activity management is recommended to avoid overactivity and to prevent deconditioning.

Although health care professionals may hesitate to give patients a diagnosis of CFS for various reasons, it’s important to receive an appropriate and accurate diagnosis to guide treatment and further evaluation. Delays in diagnosis and treatment are thought to be associated with poorer long-term outcomes. For example, CDC’s research has shown that those who have CFS for two years or less were more likely to improve. It’s not known if early intervention is responsible for this more favorable outcome; however, the longer a person is ill before diagnosis, the more complicated the course of the illness appears to be.

**Recovery from CFS**

CFS affects each individual differently. Some people with CFS remain homebound and others improve to the point that they can resume work and other activities, even though they continue to experience symptoms.

Recovery rates for CFS are unclear. Improvement rates varied from 8% to 63% in a 2005 review of published studies, with a median of 40% of patients improving during follow-up. However, full recovery from CFS may be rare, with an average of only 5% to 10% sustaining total remission.

**Possible Causes of CFS**

Despite an intensive, nearly 20-year search, the cause of CFS remains unknown. Many different infectious agents and physiologic and psychological causes have been considered, and the search continues. Much of the ongoing research into a cause has centered on the roles of the immune, endocrine and nervous systems may play in CFS. More recently, interactions among these factors are under evaluation. Genetic and environmental factors may play a role in developing and/or prolonging the illness, although more research is needed to confirm this. CDC is applying cutting-edge genomic and proteomic tools to understand the origins and pathogenesis of CFS.

CFS is not caused by depression, although the two illnesses often coexist, and many patients with CFS have no psychiatric disorder.
Links

CFS Facts (CDC)*
This site is an excellent source of general information on CFS as well as programs supported by the Center for Disease Control and Prevention. The CDC monitors and studies diseases that occur in the USA.
http://www.cdc.gov/ncidod/diseases/cfs/index.htm

CFS Facts (NLM)*
This site is a compilation of articles on CFS, summaries, and interactive tutorials, provided by the National Library of Medicine in Bethesda, MD.

FM Facts (NLM)*
This site is a compilation of articles on FM, summaries, and interactive tutorials, provided by the National Library of Medicine in Bethesda, MD.

CFIDS Association of America
The CAA is America’s largest and most reliable patient advocacy organization. The website provides current information, links, and a access to articles previously published by the organization.
http://www.cfids.org

American Fibromyalgia Syndrome Association
AFSA is a major provider of patient advocacy and research funds with regard to FM.
http://www.afsafund.org

FM Network
This site provides information and brochures on FM, as well as access to “Fibromyalgia Network” newsletter, which summarizes the latest FM information and research.
http://www.fmnetnews.com/

CFIDS / FM Self Help
Dr. Bruce Campbell was an educator with the Stanford chronic illness project when he was struck with CFS/ME in 1997. By following a Stepwise Approach, journaling, and slowly but steadily increasing his activity level, Campbell was able to recover from his illness within 5 years. He has now produced a book (with a forward written by Dr. Lapp) and supervises a 6 week internet-based self improvement course. For details go to www.cfidsselfhelp.org.

Co-Cure
Co-cure is a patient-run information exchange.
https://listserv.nodak.edu/archives/co-cure.html

The Pediatric Network
A website network for parents, youth, and professionals concerned with chronic fatigue syndrome, fibromyalgia, and orthostatic intolerance.
http://www.pediatricnetwork.org/

WebMD
This AMA-sponsored commercial site provides trustworthy, credible, and timely health information.
http://webMD.com
Outline of Initial Therapy of CFS/ME

Keep these goals in mind…

- Balance rest with low levels of activity
  - Set aside 2-3 periods of supine, quiet rest each day
- Stay active but not too active
  - Recognize that energy is no longer boundless, but finite
  - Set up a daily schedule or regimen
  - Stay within your limits of energy (that is, avoid “pushing and crashing”)
- Use good sleep hygiene, namely:
  - Use the bed for sleeping only
  - Avoid stimulant foods and beverages at night
  - Keep a sleep schedule by getting up every morning at the same time
  - Try not to take daytime naps (although short rest periods are fine)
  - Aim for 8-10 hours of sleep nightly
- Develop an easy, low level, aerobic exercise program
  - Walking, stationary cycling, and swimming are best
  - Start with 3-5 minutes of exercise at a time, followed by 5 minute rest
  - Increase exercise time slowly, do as many repetitions as your are comfortable
  - Try to exercise daily or every other day

Recognize that there are no cures for CFS/ME, but like many chronic illnesses the symptoms can be managed effectively.

Persons with CFS/ME (or PWCs) are frequently sensitive to medications, especially sedatives. Therefore, start with low doses and advance slowly (“start low, go slow”).

Treat the major symptoms first. These are:

Sleep.
Sleep initiation therapies might include:
- Melatonin, valerian
- Diphenhydramine, Tylenol PM
- Sonata / zaleplon or Lunesta / escopiclone
- Ambien / zolpidem
- Klonopin 0.5-1mg or other benzodiazepine

Sleep maintenance mightl include:
- Trazadone
- Doxepin, nortriptyline, or amitriptyline

Pain
- Follow the WHO Stepladder approach
- Tramadol (as Ultracet or Ultram) has been shown to reduce both pain and tenderpoints when used regularly.

Fatigue
- SSRIs, NSRIs, and other antidepressants may reduce irritability, sleeplessness, mood disorders, and pain caused by a deficiency of neurotransmitters
- Excessive daytime sleepiness may respond to sleep management and/or stimulants such as modafanil / Provigil, amphetamine, or methylphenidate

On subsequent visits you may wish to treat secondary problems such as

Dyscognition
- Orthostatic hypotension (if present)
Hormonal imbalances
Allergies
Also, many syndromes occur frequently in PWCs, including irritable bowel syndrome, overactive bladder, TMJ syndrome, restless leg syndrome, chemical sensitivities, vasomotor (autonomic or non-allergic) rhinitis, gut motility disorder with dysphagia, early satiety, nausea, and/or constipation, sprue-like disorders with sensitivity to wheat, grains, or gluten, autonomic dysfunction with low blood pressure, orthostatic symptoms or syncope, sicca complex or a Sjogren's-like syndrome, vulvodynia or vulvar vestibulitis, joint hyperlaxity, milk protein intolerance, costochondritis, and metabolic syndrome.
Visit 3 and Thereafter

Goal: Routine follow-up.

Ask your patient to limit follow-up office visits to one or two of the most bothersome symptoms.

Briefly inquire about the four cardinal symptoms:
   - Pain
   - Dyscognition
   - Fatigue
   - Sleep quality

Be sure to specifically comment on your patient's impairments and disability.

For ease and consistency, you may wish to use an Interim Questionnaire such as the one shown in Chart below.
RETURN OFFICE VISIT – INTERIM QUESTIONNAIRE

Name _____________________________________________       Date __________________________

What are your three top symptoms or concerns today?
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Have you had any hospitalizations since last seen?   [ ] No     [ ] Yes   (give details, including name of
hospital):
_____________________________________________________________________________

Have you had any major illness, injuries, or wrecks since last seen?   [ ] No     [ ] Yes   (give details)
_____________________________________________________________________________

Have you had any special medical studies (MRI, EEG, biopsies, endoscopies, etc.) since last seen?   [ ] No
[ ] Yes: _____________________________________________________________________
_____________________________________________________________________

Have you had an allergic reaction since last seen?  [ ] No
[ ] Yes    _____________________________________________________________________

Have you had any of the following routine studies since last seen (circle the ones you have had):

CBC  Blood chemistry  Thyroid  Diabetes check
ANA (lupus)  Lyme  Sed rate  Urinalysis  Other

Indicate the severity of your symptoms by marking a carat (V) on the 10 point scales below:

Sleep
 Poor                                            Excellent

Fatigue
 None                                            Severe

Cognition problems
 None                                            Severe

Overall Body Pain
(without pain meds)
 None                                            Severe

Overall Body Pain
(with pain meds)
 None                                            Severe
The Activity Ratio

In an average day, please estimate how many hours you spend:

Asleep in bed ......................... __________

Resting ................................. __________
(sitting or lying quietly)

Doing light or sedentary activity … __________
(lift <20#, carry 10#, walk, stand, push/pull)

Doing moderate or heavy activity … __________
(carry 10-25#, vacuum, rake, shopping)

TOTAL (must add to 24 hours) __________

[ ] Rest total

[ ] Activity total

[ ] Ratio (nl 0.5-1.0)

Functional Capacity

For how long can you sit still (e.g., watch TV)? __________

For how long can you stand in place (e.g., stand in line)? __________

For how long can you stroll or shop leisurely without resting? __________

Do you have difficulty working overhead? [ ] Yes [ ] No
Do you have difficulty manipulating small objects? [ ] Yes [ ] No
Do you have difficulty holding things? [ ] Yes [ ] No
Do you have difficulty kneeling? [ ] Yes [ ] No
Do you have difficulty bending or stooping (e.g. change bed)? [ ] Yes [ ] No
Do you have difficulty getting up from a chair? [ ] Yes [ ] No
Do you have difficulty getting up from the floor? [ ] Yes [ ] No
Do you have trouble getting out of a tub bath? [ ] Yes [ ] No

How much can you lift? Put an X in the appropriate box, where

INFREQUENT means sporadically or uncommonly, up to occasionally
OCCASIONAL means 1 to 33% of an 8-hour work day
FREQUENT means in excess of 33% of an 8-hour work day

<table>
<thead>
<tr>
<th>Weight or object</th>
<th>Not at all</th>
<th>Infrequently</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>All day…</th>
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<tbody>
<tr>
<td>5 pounds</td>
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<tr>
<td>A gallon jug</td>
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<td>10 pounds</td>
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<td>20 pounds</td>
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<tr>
<td>25# of pet food</td>
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<tr>
<td>More than 25 pounds</td>
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</table>
Cognition

Check the cognitive problems that bother you:

- [ ] Concentration (reading a book)
- [ ] Comprehension (understanding what you just read)
- [ ] Short term memory (forget recent conversations and events)
- [ ] Long term memory (forget events in the distant past)
- [ ] Calculation (mental math, making change, keeping a checkbook)
- [ ] Verbal expression (searching for words, slips of the tongue)
- [ ] Disorientation (temporarily lost in even familiar surroundings)
- [ ] Confusion (can’t remember how to do simple familiar tasks like run the computer, turn on the windshield wipers)

Exercise and Health-Enhancing Activities

Do you have a regular stretching or exercise program? [ ] Yes [ ] No

Describe it: ______________________________________________________________

______________________________________________________________________

In what health-enhancing activities do you participate (circle or underline activities):

<table>
<thead>
<tr>
<th>Massage</th>
<th>Acupuncture</th>
<th>Meditation</th>
<th>Ice / heat</th>
<th>Relaxation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prayer</td>
<td>Visual imagery</td>
<td>Paraffin bath</td>
<td>Tai chi</td>
<td>Yoga</td>
</tr>
<tr>
<td>Quai gong</td>
<td>Chiropracty</td>
<td>Pool therapy</td>
<td>Spa / tub soaks</td>
<td>Massager (electric)</td>
</tr>
<tr>
<td>Others</td>
<td></td>
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</tbody>
</table>
# Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adson’s Sign</td>
<td>Canadian Clinical Criteria <a href="http://www.cfids-cab.org/MESA/ccpc.html">http://www.cfids-cab.org/MESA/ccpc.html</a></td>
</tr>
<tr>
<td>Digit Span</td>
<td>This is a test of attention and concentration. The subject is asked to repeat a series of numbers read to him by the examiner. Test for retention of digits forward first. When the upper range is determined, test for retention of digits in reverse. The digits should be spoken at one per second, and not grouped. Stop after two failures in any given series. Less than 7 digits forward and 5 digits in reverse is abnormal; less than 5 digits forward and 3 digits in reverse is well below average. Significant difficulty on this test should trigger consideration of full neuropsychiatric testing. Suggested digit series: 518, 6501, 37514, 239715, 4391697.</td>
</tr>
<tr>
<td>Hyperextensibility</td>
<td>International CFS Criteria <a href="http://www.cdc.gov/cfs/cfsfullcasedefinition.htm">http://www.cdc.gov/cfs/cfsfullcasedefinition.htm</a></td>
</tr>
<tr>
<td>Myofascial bands</td>
<td></td>
</tr>
<tr>
<td>Orthostatic hypotension</td>
<td></td>
</tr>
<tr>
<td>Phelan’s Sign</td>
<td></td>
</tr>
<tr>
<td>Serial 7 Subtraction</td>
<td>This is a test of concentration in which the subject is asked to serially subtract 7 from one hundred as rapidly and as audibly as possible. The average time for completion is up to 90 seconds, and more than 4 errors is abnormal. It is not a test of mathematical ability alone. Before arithmetical errors are noted the subject may demonstrate hesitation or questioning, request a new start, or become upset or irritable. This should be noted. Abnormalities should trigger consideration of full neuropsychiatric testing.</td>
</tr>
<tr>
<td>Tenderpoints</td>
<td></td>
</tr>
<tr>
<td>Tinel’s Sign</td>
<td></td>
</tr>
</tbody>
</table>