Physical health questionnaires

Name/initials: Date:

Patient Health Questionnaire - Physical symptoms (PHQ-15)

During the past 4 weeks, how much have you been bothered by any of the following problems? *(Circle one number for each question)*	**Not bothered at all**	**Bothered a little**	**Bothered a lot**
1. Stomach pain	0	1	2
2. Back pain	0	1	2
3. Pain in your arms, legs, or joints (knees, hips etc.)	0	1	2
4. (Women only) Menstrual cramps or other problems with your periods	0	1	2
5. Headaches	0	1	2
6. Chest pain	0	1	2
7. Dizziness	0	1	2
8. Fainting spells	0	1	2
9. Feeling your heart pound or race	0	1	2
10. Shortness of breath	0	1	2
11. Pain or problems during sexual intercourse	0	1	2
12. Constipation, loose bowels or diarrhoea	0	1	2
13. Nausea, gas, or indigestion	0	1	2
14. Feeling tired or having low energy	0	1	2
15. Trouble sleeping	0	1	2
		Total	

Francis Irritable Bowel Scale (IBS-SSS)

For each question, please circle the number that best applies to you

Question 1: how severe has your abdominal (tummy) pain been over the last ten days?

0	1	2	3	4	5	6	7	8	9	10
No pain		Not very severe			Quite severe			Severe		Very severe

Question 2: on how many of the last ten days did you get pain?

0	1	2	3	4	5	6	7	8	9	10

Question 3: how severe has your abdominal distension (bloating, swollen, or tight) been over the last ten days?

0	1	2	3	4	5	6	7	8	9	10
No distension		Not very severe			Quite severe			Severe		Very severe

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Question 4: how satisfied have you been with your bowel habit (frequency, ease etc.) over the past ten days?

0	1	2	3	4	5	6	7	8	9	10
Very happy				Quite happy			Unhappy			Very unhappy

Question 5: how much has your IBS been affecting/interfering with your life in general over the last ten days?

0	1	2	3	4	5	6	7	8	9	10
Not at all				Not much			Quite a lot			Completely

Total: _____ Total (x10): ---------

Chalder Fatigue Questionnaire (CFQ)

We would like to know more about any problems you have had with feeling tired, weak, or lacking in energy in the last month. Please answer ALL the questions by ticking the answer which applies to you most closely. If you have been feeling tired for a long while, then compare yourself to how you felt when you were last well. Please tick only one box per line.

Circle one number for each question	**Less than usual**	**No more than usual**	**More than usual**	**Much more than usual**
1. Do you have problems with tiredness?	0	1	2	3
2. Do you need to rest more?	0	1	2	3
3. Do you feel sleepy or drowsy?	0	1	2	3
4. Do you have problems starting things?	0	1	2	3
5. Do you lack energy?	0	1	2	3
6. Do you have less strength in your muscles?	0	1	2	3
7. Do you feel weak?	0	1	2	3
8. Do you have difficulties concentrating?	0	1	2	3
9. Do you make slips of the tongue when speaking?	0	1	2	3
10. Do you find it more difficult to find the right word?	0	1	2	3
	Better than usual	**No worse than usual**	**Worse than usual**	**Much worse than usual**
11. How is your memory?	0	1	2	3
			Total	