FATIGUE SCALE

Name_____ **Date**_____

We are interested in the extent that you have felt **fatigued** (tired, weary, exhausted) over the last **two weeks**. We **do not** mean feelings of **sleepiness** (the likelihood of falling asleep). Please circle the appropriate response in accordance with your average feelings over this two-week period.

Was fatigue a problem for you?

0	1	2	3	4
Not at all		Moderately		Extremely

Did fatigue cause problems with your everyday functioning (e.g., work, social, family)?

0	1	2	3	4
Not at all		Moderately		Extremely

Did fatigue cause you distress?

0	1	2	3	4
Not at all		Moderately		Extremely

How often did you suffer from fatigue?

0	1	2	3	4
0 days/ week	1-2 days/ week	3-4 days/ week	5-6 days/ week	7 days/ week

At what time(s) of the day did you typically experience fatigue? (Please tick box(es))

Early morning	☐	Late afternoon	☐
Mid morning	☐	Early evening	☐
Midday	☐	Late evening	☐
Mid afternoon	☐		

How severe was the fatigue you experienced?

0	1	2	3	4
Not at all		Moderate		Extreme

How much was your fatigue caused by poor sleep?

0	1	2	3	4
Not at all		Moderately		Entirely

Gradisar et al J Clin Sleep Med. 2007 Dec 15;3(7):722-8.
http://www.ncbi.nlm.nih.gov/pubmed/18198807