

# Back In Action Chiropractic

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## Fibromyalgia/Chronic Fatigue Syndrome Questionnaire

NAME \_\_\_\_\_ DATE \_\_\_\_\_

Place a check mark next to all of the following that apply to you.

### Predisposing Factors

1. \_\_\_ I have had one or more stressful events that have affected my health
2. \_\_\_ I have continuous stressors that affect my health
3. \_\_\_ I have developed FM/CFS following an accident or injury
4. \_\_\_ I have developed FM/CFS following a stressful event
5. \_\_\_ I push myself to exhaustion
6. \_\_\_ I have little time or energy to care for myself (eat regularly, rest, etc.)
7. \_\_\_ I have a very stressful job
8. \_\_\_ I do not enjoy my line of work
9. \_\_\_ I have little or no control over the stress in my life
10. \_\_\_ I currently have relationship or family difficulties
11. \_\_\_ My state of ill-health is a major stress factor
12. \_\_\_ I do not have a good support system of friends and family
13. \_\_\_ I have a history of physical, emotional, or sexual abuse
14. \_\_\_ I do not sleep well
15. \_\_\_ I have or have had an eating disorder
16. \_\_\_ I eat mostly a processed food/fast food diet
17. \_\_\_ I do not exercise regularly

### Contributing Factors

1. \_\_\_ Antacid use – How long? \_\_\_\_\_
2. \_\_\_ I take or have taken Prilosec, Prevacid, Nexium, or another acid-stopping medication – How long? \_\_\_\_\_
3. \_\_\_ Multiple rounds of antibiotic use? Please explain: \_\_\_\_\_
4. \_\_\_ Long-term steroid use? Please explain: \_\_\_\_\_
5. \_\_\_ I drink more than two glasses of an alcoholic beverage per day
6. \_\_\_ Irritable bowel syndrome
7. \_\_\_ Gall bladder removed – When? \_\_\_\_\_
8. \_\_\_ Chron's disease
9. \_\_\_ Allergies – To what? \_\_\_\_\_
10. \_\_\_ Parasites
11. \_\_\_ Candida
12. \_\_\_ Low blood pressure
13. \_\_\_ Skin condition – Please explain: \_\_\_\_\_
14. \_\_\_ I tend to be anemic
15. \_\_\_ I have been diagnosed with a sleep disorder – Please explain: \_\_\_\_\_
16. \_\_\_ I take or have taken oral contraceptives – What, when, and for how long? \_\_\_\_\_
17. \_\_\_ I am menopausal or perimenopausal
18. \_\_\_ I take or have taken conventional HRT – What, when, and for how long? \_\_\_\_\_
19. \_\_\_ Hysterectomy – Ovaries removed? \_\_\_

How long have you felt like this?

I have not felt well since \_\_\_\_\_ (date)

What happened at that time? (Describe any event, situation, etc.)

## Signs and Symptoms Questions

Rate the following on a scale of 0 to 5, with 0 being "not present" and 5 being "severe."

- |  |  |
|--|--|
| 1. ___ Fatigue   | 40. ___ Acid reflux  |
| 2. ___ Need to rest a lot more than I used to                    | 41. ___ Loss of taste for meat   |
| 3. ___ Difficulty getting to sleep                               | 42. ___ Burning when stomach is empty  |
| 4. ___ Difficulty staying asleep                                 | 43. ___ Gall bladder problems / Gall bladder has been removed                    |
| 5. ___ Non-restful sleep   | 44. ___ Diarrhea   |
| 6. ___ Slow starter  | 45. ___ Constipation   |
| 7. ___ Less productive with work                                 | 46. ___ Swollen lymph glands   |
| 8. ___ Get sleepy during the day                                 | 47. ___ Sore throat  |
| 9. ___ Less energy for or interest in things I enjoy             | 48. ___ Chronic sinus congestion   |
| 10. ___ Poor stamina   | 49. ___ Chronic or recurring infections  |
| 11. ___ Trouble focusing on work or projects                     | 50. ___ Skin rashes  |
| 12. ___ Little or no energy for exercising                       | 51. ___ Itching skin   |
| 13. ___ No energy left over for anything that I don't have to do | 52. ___ Dry eyes, nose, and/or mouth   |
| 14. ___ Difficulty handling pressure or stress                   | 53. ___ Vision changes, becoming blurred or weaker                               |
| 15. ___ Do not feel well   | 54. ___ Difficulty concentrating   |
| 16. ___ Muscle pains/aches – Where? _____                        | 55. ___ Poor memory  |
| 17. ___ Muscle spasms – Where? _____                             | 56. ___ Brain fog  |
| 18. ___ Joint pains – Where? _____                               | 57. ___ Confusion  |
| 19. ___ Numbness or tingling – Where? _____                      | 58. ___ Anxiety  |
| 20. ___ Burning pains – Where? _____                             | 59. ___ I feel constantly stressed   |
| 21. ___ Other pains – where? _____                               | 60. ___ Become agitated or irritated or lose patience more easily than I used to |
| 22. ___ Stiffness  | 61. ___ I am more moody than I used to be  |
| 23. ___ Poor muscle tone or strength                             | 62. ___ Panic attacks  |
| 24. ___ Feel weak  | 63. ___ Low mood   |
| 25. ___ Flu-like feelings  | 64. ___ Depression   |
| 26. ___ Exercise intolerance (excessive pain after exercise)     | 65. ___ Low self-esteem  |
| 27. ___ Prolonged fatigue after exertion                         | 66. ___ Feelings of worthlessness  |
| 28. ___ Increased pain sensitivity                               | 67. ___ Feelings of despair  |
| 29. ___ Increased sensitivity to noise, light, and/or touch      | 68. ___ Loss of interest in daily activities                                     |
| 30. ___ I have trouble slowing down or relaxing                  | 69. ___ Loss of or less enjoyment in living                                      |
| 31. ___ Headaches or migraines                                   | 70. ___ Withdrawn from social activities   |
| 32. ___ Neck or shoulder tension                                 | 71. ___ Low self-confidence  |
| 33. ___ Cold hands or feet                                       | 72. ___ I have trouble making decisions  |
| 34. ___ Tend to be cold all over                                 | 73. ___ Hypoglycemia (low blood sugar)   |
| 35. ___ Indigestion  | 74. ___ Sweet, chocolate, or carbohydrate craving                                |
| 36. ___ Bloating   | 75. ___ Salt craving   |
| 37. ___ Belching   | 76. ___ Alcohol craving  |
| 38. ___ Gas  | 77. ___ Shakiness relieved by eating   |
| 39. ___ Nausea   |  |
| _____ Column 1 total   | _____ Column 2 total   |

- |  |   |
|--|---|
| 78. ___ Get shaky, irritable, or headache if a meal is skipped | 97. ___ Vaginal dryness, irritation, or infections          |
| 79. ___ Tired after meals                                      | 98. ___ Hot flashes   |
| 80. ___ I eat a low fat diet                                   | 99. ___ Night sweats  |
| 81. ___ I restrict my salt intake                              | 100. ___ PMS  |
| 82. ___ I eat a lot of dairy                                   | 101. ___ Infertility  |
| 83. ___ I eat a lot of sugar                                   | 102. ___ Heavy bleeding, clotting, or cramping with periods |
| 84. ___ I drink a lot of sodas                                 | 103. ___ Irregular periods                                  |
| 85. ___ Dizziness  | 104. ___ Decreased libido                                   |
| 86. ___ Light-headed upon arising                              | 105. ___ Erectile dysfunction                               |
| 87. ___ Brown spots appearing on skin                          | 106. ___ Weight gain, especially around the middle          |
| 88. ___ Unexplained fears or worries                           | 107. ___ Unexplained weight loss                            |
| 89. ___ Excessive fears or worries                             | 108. ___ Bruise easily                                      |
| 90. ___ Snoring  | 109. ___ Heavy/aching legs                                  |
| 91. ___ Restless legs  | 110. ___ Edema (water retention)                            |
| 92. ___ Arms and/or legs jerk when in bed                      | 111. ___ Become short of breath easily                      |
| 93. ___ Grind teeth at night                                   | 112. ___ Chest pain   |
| 94. ___ Urinary frequency                                      | 113. ___ Palpitations                                       |
| 95. ___ Night-time urinary frequency                           | 114. ___ Most people don't understand my condition          |
| 96. ___ Urinary tract infection                                | 115. ___ Little or no support from friends or family        |
| ___ Column 3 total   | ___ Column 4 total  |

Total from Column 1: \_\_\_\_\_  
 Total from Column 2: \_\_\_\_\_  
 Total from Column 3: \_\_\_\_\_  
 Total from Column 4: \_\_\_\_\_  
 Grand Total: \_\_\_\_\_

100-200: Moderate or early stage FM/CFS  
 201-325: Severe FM/CFS  
 326-580: Extreme FM/CFS

**History**

List any conditions that you have been diagnosed with, with dates where possible.

List any medications that you are taking.

List any nutritional supplements and/or herbs that you are taking.

Describe anything else you feel is contributing to your condition, or add any other relevant comments.