

Instructions for the DePaul Pediatric Health Questionnaire

The DePaul Pediatric Health Questionnaire (DPHQ) is used among children who are under the age of 18 years old. It can be administered to 12 -17 year olds as a self-report or for children younger than 12 years old, an adult guardian should fill out the questionnaire along with the child. The adult guardian should record the answers given by the child, unless the child is unable to recall information.

Only one questionnaire should be completed so that there is only one set of data for each participant. It is important to emphasize mutuality and agreement of reporting between child and adult guardian when completing the questionnaire. Guardian parents may remember and recall the child's experiences and symptoms better than the child can. At the same time, they may also remember inaccurate or incomplete information that disagrees with the child's experiences and symptoms. If an adult is assisting a child in filling out the questionnaire, it is important that the pair comes to a consensus so that duplicate data is not provided.

If the child is at a location away from adult guardians, such as a school or a tertiary care center, an adult such as a nurse or a teacher may simply record the child's responses to the questionnaire. Mutuality and agreement of reporting cannot exist in such cases, but a child report is adequate, as long as it is based on an adult's assistance in administering the questionnaire to the child.

All children under age 18 who have a chronic illness such as CFS or cancer should have the assistance of an adult, in order to reduce respondent burden and increase accuracy of reporting.

Scoring Sheet: To meet criteria, a symptom must have a rating for Frequency and Severity of 4 or more, and be of 3 months or longer duration

Categories	Question	Frequency	Severity	Duration	
I. Fatigue: Question 8	8	<input type="text"/>	<input type="text"/>	<input type="text"/>	Meets Fatigue Criterion Yes_____
II. Post-Exertional Malaise: Question 9	9	<input type="text"/>	<input type="text"/>	<input type="text"/>	Meets Post-Exertional Malaise Criterion Yes_____
III. Sleep: At least one symptom from Questions 10 to 14	10	<input type="text"/>	<input type="text"/>	<input type="text"/>	Meets Sleep Criterion Yes_____
	11	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	12	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	13	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	14	<input type="text"/>	<input type="text"/>	<input type="text"/>	
IV. Pain: At least one symptom from Questions 15 to 25	15	<input type="text"/>	<input type="text"/>	<input type="text"/>	Meets Pain Criterion Yes_____
	16	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	17	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	18	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	19	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	20	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	21	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	22	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	23	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	24	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	25	<input type="text"/>	<input type="text"/>	<input type="text"/>	
V. Neurocognition: At least two symptoms from Questions 26 to 34	26	<input type="text"/>	<input type="text"/>	<input type="text"/>	Meets Neurocognition Criterion Yes_____
	27	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	28	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	29	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	30	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	31	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	32	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	33	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	34	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	VI. Other Category: Autonomic manifestations: Questions 35 to 38 Neuroendocrine manifestations: Questions 39 to 46 Immune manifestations: Questions 47 to 50	35	<input type="text"/>	<input type="text"/>	
36		<input type="text"/>	<input type="text"/>	<input type="text"/>	
37		<input type="text"/>	<input type="text"/>	<input type="text"/>	
38		<input type="text"/>	<input type="text"/>	<input type="text"/>	
39		<input type="text"/>	<input type="text"/>	<input type="text"/>	
40		<input type="text"/>	<input type="text"/>	<input type="text"/>	
41		<input type="text"/>	<input type="text"/>	<input type="text"/>	
42		<input type="text"/>	<input type="text"/>	<input type="text"/>	
43		<input type="text"/>	<input type="text"/>	<input type="text"/>	
44		<input type="text"/>	<input type="text"/>	<input type="text"/>	
45		<input type="text"/>	<input type="text"/>	<input type="text"/>	
46		<input type="text"/>	<input type="text"/>	<input type="text"/>	
47		<input type="text"/>	<input type="text"/>	<input type="text"/>	
48		<input type="text"/>	<input type="text"/>	<input type="text"/>	
49		<input type="text"/>	<input type="text"/>	<input type="text"/>	
50	<input type="text"/>	<input type="text"/>	<input type="text"/>		

Diagnosis
<p>_____ Severe ME/CFS Meets Criteria for categories I, II, III, IV V and VI</p> <p>_____ Moderate ME/CFS Meets Criteria for 5 of the 6 categories. Also, for Category VI, only one criterion symptom is needed.</p> <p>_____ Atypical ME/CFS (Reporting 4 or fewer criteria categories).</p> <p>_____ ME/CFS-Like (Exhibiting all criteria symptoms but not for a duration of three or more months).</p> <p>_____ Remission (Met full symptom criteria at one time but not currently experiencing severe or moderate symptomology).</p>

Child Name _____

Date _____

DePaul Pediatric Health Questionnaire (Child Version)

For all of the following questions, please provide or circle only one answer unless otherwise asked.

1. How old are you? _____

2. Are you male or female?

Male 1

Female 2

3. Are you of Latino or Hispanic origin?

Yes 1

No 2

4. To which of the following race(s) do you belong?

Black, African-American 1

White 2

American Indian or Alaska Native 3

Asian or Pacific Islander 4

Some other race (***Please write-in below***) 5

5. What grade are you in or what was the last grade that you completed? _____

6. Do you attend school or do you have home-schooling/homebound instruction?

Attend School 1

Attend School Part-time 2

Home-school/Homebound Instruction (***Please write-in below***) 3

When did you start home-schooling/Homebound Instruction? _____

7. How many days of school do you usually miss in one month? _____

Please fill out this chart (go from left to right)

Symptoms	Please write the number of months you have experienced this symptom below	<i>Frequency:</i> How often do you have this symptom? Please circle a number from 1-7 using this scale							<i>Severity:</i> How much does this symptom bother you? Please circle a number from 1-7 using this scale						
		Hardly Ever 1	2	3	Half of the time 4	5	6	Always 7	No Problem 1	2	3	Moderate Problem 4	5	6	Big Problem 7
8) Fatigue/ Extreme tiredness		1	2	3	4	5	6	7	1	2	3	4	5	6	7
9) Feeling worse after doing activities that require physical or mental effort		1	2	3	4	5	6	7	1	2	3	4	5	6	7
10) Feeling tired after you wake up in the morning		1	2	3	4	5	6	7	1	2	3	4	5	6	7
11) Need to nap daily		1	2	3	4	5	6	7	1	2	3	4	5	6	7
12) Problems falling asleep		1	2	3	4	5	6	7	1	2	3	4	5	6	7
13) Problems staying asleep		1	2	3	4	5	6	7	1	2	3	4	5	6	7
14) Waking up early in the morning (like 3am)		1	2	3	4	5	6	7	1	2	3	4	5	6	7
15) Pain or aching in your muscles		1	2	3	4	5	6	7	1	2	3	4	5	6	7
16) Muscle twitches		1	2	3	4	5	6	7	1	2	3	4	5	6	7
17) Pain/stiffness/tenderness in more than one joint without swelling or redness		1	2	3	4	5	6	7	1	2	3	4	5	6	7
18) Eye pain		1	2	3	4	5	6	7	1	2	3	4	5	6	7
19) Vomiting		1	2	3	4	5	6	7	1	2	3	4	5	6	7
20) Nausea		1	2	3	4	5	6	7	1	2	3	4	5	6	7
21) Chest pain or heartburn		1	2	3	4	5	6	7	1	2	3	4	5	6	7
22) Upset stomach		1	2	3	4	5	6	7	1	2	3	4	5	6	7
23) Abdomen/stomach pain		1	2	3	4	5	6	7	1	2	3	4	5	6	7
24) Ringing in ears		1	2	3	4	5	6	7	1	2	3	4	5	6	7
25) Headaches		1	2	3	4	5	6	7	1	2	3	4	5	6	7
26) Problems remembering things		1	2	3	4	5	6	7	1	2	3	4	5	6	7
27) Difficulty paying attention for a long period of time		1	2	3	4	5	6	7	1	2	3	4	5	6	7
28) Difficulty finding the right word to say		1	2	3	4	5	6	7	1	2	3	4	5	6	7

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		Hardly Ever		Half of the time			Always		No Problem		Moderate Problem			Big Problem	
		1	2	3	4	5	6	7	1	2	3	4	5	6	7
29) Difficulty understanding things		1	2	3	4	5	6	7	1	2	3	4	5	6	7
30) Only able to focus on one thing at a time		1	2	3	4	5	6	7	1	2	3	4	5	6	7
31) Frequently losing your train of thought		1	2	3	4	5	6	7	1	2	3	4	5	6	7
32) Slowness of thought		1	2	3	4	5	6	7	1	2	3	4	5	6	7
33) Absent-mindedness or forgetfulness		1	2	3	4	5	6	7	1	2	3	4	5	6	7
34) Recent trouble with math or numbers		1	2	3	4	5	6	7	1	2	3	4	5	6	7
35) Feel unsteady on your feet, like you might fall		1	2	3	4	5	6	7	1	2	3	4	5	6	7
36) Shortness of breath or trouble catching your breath		1	2	3	4	5	6	7	1	2	3	4	5	6	7
37) Dizziness		1	2	3	4	5	6	7	1	2	3	4	5	6	7
38) Irregular heart beats		1	2	3	4	5	6	7	1	2	3	4	5	6	7
39) Losing or gaining weight		1	2	3	4	5	6	7	1	2	3	4	5	6	7
40) Not wanting to eat		1	2	3	4	5	6	7	1	2	3	4	5	6	7
41) Sweating hands		1	2	3	4	5	6	7	1	2	3	4	5	6	7
42) Night sweats		1	2	3	4	5	6	7	1	2	3	4	5	6	7
43) Feel chills or shivers		1	2	3	4	5	6	7	1	2	3	4	5	6	7
44) Feeling hot or cold		1	2	3	4	5	6	7	1	2	3	4	5	6	7
45) Feeling like you have a high temperature		1	2	3	4	5	6	7	1	2	3	4	5	6	7
46) Feeling like you have a low temperature		1	2	3	4	5	6	7	1	2	3	4	5	6	7
47) Sore throat		1	2	3	4	5	6	7	1	2	3	4	5	6	7
48) Tender/sore lymph nodes		1	2	3	4	5	6	7	1	2	3	4	5	6	7
49) Fever and sweats		1	2	3	4	5	6	7	1	2	3	4	5	6	7
50) Some smells, foods, or chemicals make you feel sick		1	2	3	4	5	6	7	1	2	3	4	5	6	7
51) Rash(es)		1	2	3	4	5	6	7	1	2	3	4	5	6	7
52) Allergies		1	2	3	4	5	6	7	1	2	3	4	5	6	7
53) Mood changes		1	2	3	4	5	6	7	1	2	3	4	5	6	7
54) Anxiety		1	2	3	4	5	6	7	1	2	3	4	5	6	7

55. If you have headaches now, do you get them more often, in a different place, or do the headaches feel worse than they did in the past? (You may circle more than one answer.)

Headaches happen more often 1
 Headaches feel worse/more severe 2
 Headaches are in a different place/spot 3

56. Do you have any medical illness(es) that might be causing your symptoms?

No 1

Yes (***What medical illnesses do you have?***) 2

Illness name(s): _____

Date(s) of onset or diagnosis: _____

57. Do you seem to catch illnesses more easily than other people your age?

No 1

Yes 2

58. Does it seem to take you longer to get better after you are sick than other people your age?

No 1

Yes 2

59. How does being physically active (such as using stairs, walking, playing sports, doing chores, getting dressed) make you feel for the rest of the day?

Much more tired than usual 1

More tired than usual 2

Has no effect 3

More energetic than usual 4

Much more energetic than usual 5

60. Do you participate in any activities or hobbies outside of school?

No 1

Yes 2

61. Are you currently able to carry out your activities or hobbies?

No..... 1

Yes 2

IF NO, when and why did you quit your activities:

62. Have you been experiencing any problems with fatigue/extreme tiredness?
for at least one month?

No 1

Yes 2

IF YES, for about how many months? _____

63. What do you think the cause of your fatigue or tiredness is? (Skip to question 63 if you are not feeling fatigue or tiredness)

64. Do you think that your fatigue is caused by ongoing activity?

Yes 1

No..... 2

I do not have fatigue 3

65. Did your fatigue illness start after you experienced_____? (Circle one or more.)

An infectious illness 1

An accident 2

A trip or vacation 3

An immunization (shot at doctor's office)..... 4

Surgery..... 5

Severe stress (bad or unhappy event(s)) 6

Other (**Please write in below**) 7

I do not have fatigue 8

66. How long did it take for your problem with fatigue or tiredness to get started?

- Rapidly - within 24 hours..... 1
- Over 1 week..... 2
- Over 1 month..... 3
- Over 2-3 months..... 4
- Over 4-6 months..... 5
- Over 7-11 months..... 6
- Over 1-2 years..... 7
- Longer than 2 years 8
- I have always experienced fatigue..... 9
- I do not have fatigue 10

67. When you first became sick what were your worst 3 symptoms? (Skip to question 68 if you are not feeling fatigue or tiredness)

- a. _____
- b. _____
- c. _____

68. Right now, what are your worst 3 symptoms? (Skip to question 69 if you are not feeling fatigue or tiredness)

- a. _____
- b. _____
- c. _____

69. Do your symptoms change over time?

- No..... 1
- Yes 2
- I do not have fatigue 3

70. Do you limit or cut back your activity levels to avoid feeling even more tired?

- No..... 1
- Yes 2

71. If you rest, does all of your fatigue go away, some of it go away, or none

of it go away?

- All of it goes away 1
 Some of it goes away..... 2
 None of it goes away 3
 I do not have fatigue 4

72. How long do you have to rest before your fatigue gets better? (Skip to question 73 if you do not have fatigue)

73. Will your fatigue come back if you stop resting and start doing something?

- No..... 1
 Yes 2
 I do not have fatigue 3

74. How would you describe the way your fatigue illness is changing over time?

- My fatigue is getting worse..... 1
 I have good and bad periods..... 2
 There is no change..... 3
 My fatigue is getting better 4
 I do not have fatigue 5

75. Have you ever been diagnosed with ME/CFS by a physician?

- No 1
 Yes..... 2

If yes, when were you diagnosed? _____



Thank you for filling out the DePaul Pediatric Health Questionnaire (Child Version).

Adult Name _____

Date _____

DePaul Pediatric Health Questionnaire (Adult Version)

For all of the following questions, please provide or circle only one answer unless otherwise asked.

1. What is your child's age (in years)? _____

2. Is your child male or female?

Male 1

Female 2

3. Is your child of Latino or Hispanic origin?

Yes 1

No 2

4. To which of the following race(s) does your child belong?

Black, African-American 1

White 2

American Indian or Alaska Native 3

Asian or Pacific Islander 4

Some other race (***Please write-in below***) 5

5. What grade is your child in or what was the last grade that he/she completed? _____

6. Does your child attend school or does he/she have home-schooling/homebound instruction?

Attend School 1

Attend School Part-time 2

Home-school/Homebound Instruction (***Please write-in below***) 3

When did he/she start home-schooling/Homebound Instruction? _____

7. How many days of school does your child usually miss in one month? _____

Please fill out this chart (go from left to right)

Symptoms	Please write the number of months your child has experienced this symptom below	<i>Frequency:</i> How often does your child have this symptom? Please circle a number from 1-7 using this scale							<i>Severity:</i> How much does this symptom bother your child? Please circle a number from 1-7 using this scale						
		Hardly Ever 1	2	3	Half of the time 4	5	6	Always 7	No Problem 1	2	3	Moderate Problem 4	5	6	Big Problem 7
8) Fatigue/ Extreme tiredness		1	2	3	4	5	6	7	1	2	3	4	5	6	7
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10) Feeling tired after he/she wakes up in the morning		1	2	3	4	5	6	7	1	2	3	4	5	6	7
11) Needs to nap daily		1	2	3	4	5	6	7	1	2	3	4	5	6	7
12) Problems falling asleep		1	2	3	4	5	6	7	1	2	3	4	5	6	7
13) Problems staying asleep		1	2	3	4	5	6	7	1	2	3	4	5	6	7
14) Waking up early in the morning (like 3am)		1	2	3	4	5	6	7	1	2	3	4	5	6	7
15) Pain or aching in his/her muscles		1	2	3	4	5	6	7	1	2	3	4	5	6	7
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28) Difficulty finding the right word to say		1	2	3	4	5	6	7	1	2	3	4	5	6	7

Symptoms	Please write the number of months your child has experienced this symptom below	<i>Frequency:</i> How often does your child have this symptom?							<i>Severity:</i> How much does this symptom bother your child?						
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		1	2	3	4	5	6	7	1	2	3	4	5	6	7
29) Difficulty understanding things		1	2	3	4	5	6	7	1	2	3	4	5	6	7
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44) Feeling hot or cold		1	2	3	4	5	6	7	1	2	3	4	5	6	7
45) Feeling like he/she has a high temperature		1	2	3	4	5	6	7	1	2	3	4	5	6	7
46) Feeling like he/she has a low temperature		1	2	3	4	5	6	7	1	2	3	4	5	6	7
47) Sore throat		1	2	3	4	5	6	7	1	2	3	4	5	6	7
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55. If your child has headaches now, does he/she get them more often, in a different place, or do the headaches feel worse than they did in the past? (You may circle more than one answer.)

Headaches happen more often 1
 Headaches feel worse/more severe 2
 Headaches are in a different place/spot 3

56. Does your child have any medical illness that might be causing his/her symptoms?

No 1

Yes (***What medical illnesses does he/she have?***) 2

Illness name(s): _____

Date(s) of onset or diagnosis: _____

57. Does your child seem to catch illnesses more easily than other people his/her age?

No 1

Yes 2

58. Does it seem to take your child longer to get better after he/she is sick than other people his/her age?

No 1

Yes 2

59. How does being physically active (such as using stairs, walking, playing sports, doing chores, getting dressed) make your child feel for the rest of the day?

Much more tired than usual 1

More tired than usual 2

Has no effect 3

More energetic than usual 4

Much more energetic than usual 5

60. Does your child participate in any activities or hobbies outside of school?

No 1

Yes 2

61. Is he/she currently able to carry out his/her activities or hobbies?

No..... 1

Yes 2

IF NO, when and why did your child quit his/her activities:

62. Has your child been experiencing any problems with fatigue/extreme tiredness for at least one month?

No 1

Yes 2

IF YES, for about how many months? _____

63. What do you think is the cause of your child's fatigue or tiredness? (Skip to question 63 if he/she is not feeling fatigue or tiredness)

64. Do you think that your child's fatigue is caused by ongoing activity?

Yes 1

No..... 2

He/she does not have fatigue 3

65. Did your child's fatigue illness start after he/she experienced_____? (Circle one or more.)

An infectious illness 1

An accident 2

A trip or vacation 3

An immunization (shot at doctor's office)..... 4

Surgery..... 5

Severe stress (bad or unhappy event(s)) 6

Other (**Please write in below**) 7

He/she does not have fatigue 8

66. How long did it take for your child's problem with fatigue or tiredness to get started?

- Rapidly - within 24 hours..... 1
- Over 1 week..... 2
- Over 1 month..... 3
- Over 2-3 months..... 4
- Over 4-6 months..... 5
- Over 7-11 months..... 6
- Over 1-2 years..... 7
- Longer than 2 years 8
- He/she has always experienced fatigue 9
- He/she does not have fatigue 10

67. When your child first became sick what were his/her worst 3 symptoms? (Skip to question 68 if he/she is not feeling fatigue or tiredness)

- d. _____
- e. _____
- f. _____

68. Right now, what are your child's worst 3 symptoms? (Skip to question 69 if he/she is not feeling fatigue or tiredness)

- d. _____
- e. _____
- f. _____

69. Do his/her symptoms change over time?

- No..... 1
- Yes 2
- He/she does not have fatigue 3

70. Does your child limit or cut back his/her activity levels to avoid feeling even more tired?

- No..... 1
- Yes 2

71. If your child rests, does all of his/her fatigue go away, some of it go away, or none of it go away?

All of it goes away 1

Some of it goes away..... 2

None of it goes away 3

He/she does not have fatigue 4

72. How long does your child have to rest before his/her fatigue gets better? (Skip to question 73 if you do not have fatigue)

73. Will your child's fatigue return if he/she stops resting and starts doing something?

No..... 1

Yes 2

He/she does not have fatigue 3

74. How would you describe the way your child's fatigue illness is changing over time?

His/her fatigue is getting worse 1

He/she has good and bad periods..... 2

There is no change..... 3

His/her fatigue is getting better..... 4

He/she does not have fatigue 5

75. Has your child ever been diagnosed with ME/CFS by a physician?

No 1

Yes..... 2

If yes, when was he/she diagnosed? _____



Thank you for filling out the DePaul Pediatric Health Questionnaire (Adult Version).