Brief Fatigue Inventory

STUDY ID# ____________ HOSPITAL # ____________

Date: _____/_____ /_____ **Time:** ____________

Name ____________________ ____________________ ____________
Last First Middle Initial

Throughout our lives, most of us have times when we feel very tired or fatigued. Have you felt unusually tired or fatigued in the last week? Yes ☐ No ☐

1. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your fatigue right NOW.

0	1	2	3	4	5	6	7	8	9	10
No Fatigue										As bad as you can imagine

2. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your USUAL level of fatigue during past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Fatigue										As bad as you can imagine

3. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your WORST level of fatigue during past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Fatigue										As bad as you can imagine

4. Circle the one number that describes how, during the past 24 hours, fatigue has interfered with your:

A. General activity

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely Interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely Interferes

C. Walking ability

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely Interferes

D. Normal work (includes both work outside the home and daily chores)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely Interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely Interferes

F. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely Interferes