Date:	Name:	DOB:

Flinder's Fatigue Scale

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

		Not at all		**Moderate**		**Extremely**
1.	Was fatigue a problem for you?	0	1	2	3	4
2.	Did fatigue cause problems with your everyday functioning (e.g., work, social, family)?	0	1	2	3	4
3.	Did fatigue cause you distress?	0	1	2	3	4
4.	How severe was the fatigue you experienced?	0	1	2	3	4
5.	How much was your fatigue caused by poor sleep?	0	1	2	3	4
Your total score						

6.	**How often did you suffer from fatigue?**				
	0 Days a week	1-2 days/week	3-4 days/week	5-6 days/week	7 days/week
	0	1	2	3	4
	Score				

7.	**At what times of the day did you typically experience fatigue? If you experience fatigue at different parts of the day, mark ('X') all that apply to you.**		
		Mark with an 'X' all that apply:	Score 1 for each item that applies
	Early morning		
	Mid-morning		
	Midday		
	Mid-afternoon		
	Late afternoon		
	Early evening		
	Late evening		
		Total	

Your total score = [i.e., total for questions 1-5 + score for item 6 + Total for question 7] **=**