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

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