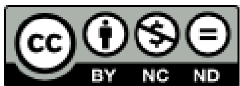
SymTrak-8 Version 1.0 – Patient Report Form

PLEASE CIRCLE ONLY 1 ANSWER ON EACH ROW

OVER THE PAST **TWO WEEKS**, HOW OFTEN HAVE YOU HAD PROBLEMS WITH:					
1.	Feeling tired or having low energy	**Never**	**Sometimes**	**Often**	**Always**
2.	Trouble falling asleep or trouble staying asleep	**Never**	**Sometimes**	**Often**	**Always**
3.	Pain interfering with daily activities	**Never**	**Sometimes**	**Often**	**Always**
4.	Trouble with vision or hearing	**Never**	**Sometimes**	**Often**	**Always**
5.	Trouble walking or trouble moving around	**Never**	**Sometimes**	**Often**	**Always**
6.	Feeling sad, down, depressed, or having less interest in doing things	**Never**	**Sometimes**	**Often**	**Always**
7.	Feeling nervous, anxious, or worrying too much	**Never**	**Sometimes**	**Often**	**Always**
8.	Trouble concentrating on things or memory loss	**Never**	**Sometimes**	**Often**	**Always**



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