Date: _____ **Institution:**_____

Participant Initials: _____ **Hospital Chart #:**_____

Participant Number: _____

MD Anderson Symptom Inventory - Traditional Chinese Medicine (MDASI-TCM)

Part I. How **severe** are your symptoms?

Patients frequently have symptoms that are caused by their disease or by their treatment. We ask you to rate how severe the following symptoms have been ***in the last 24 hours***. Please select a number from 0 (symptom has not been present) to 10 (the symptom was as bad as you can imagine it could be) for each item.

	Not Present 0	1	2	3	4	5	6	7	8	9	**As Bad As You Can Imagine** 10
1. Your **pain** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
2. Your **fatigue (tiredness)** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
3. Your **nausea** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
4. Your **disturbed sleep** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
5. Your feeling of being **distressed (upset)** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
6. Your **shortness of breath** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
7. Your problem with **remembering things** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
8. Your problem with **lack of appetit** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
9. Your feeling **drows** WORST?	○	○	○	○	○	○	○	○	○	○	○
10. Your having a **dry mouth** WORST?	○	○	○	○	○	○	○	○	○	○	○
11. Your feeling **sad** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
12. Your **vomiting** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
13. Your **numbness or tingling** at its WORST?	○	○	○	○	○	○	○	○	○	○	○

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Participant Number: _____

	Not Present 0	1	2	3	4	5	6	7	8	9	As Bad As You Can Imagine 10
14. Your problem with **sweating** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
15. Your problem with **feeling cold** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
16. Your **constipation** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
17. Your problem with **bitter taste** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
18. Your **coughing** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
19. Your problem with **palpitation (racing heartbeat)** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
20. Your problem with **heat in palms or soles** at its WORST?	○	○	○	○	○	○	○	○	○	○	○

Part II. How have your symptoms **interfered** with [illegible]?

Symptoms frequently interfere with how w[illegible]. How much have your symptoms interfered with the following items ***in the last 24 hours***? P[illegible] a number from 0 (symptoms have not interfered) to 10 (symptoms interfered completely) for each item.

	Di[illegible]t In 1	2	3	4	5	6	7	8	9	Interfered Completely 10
21. **General activity?**	○	○	○	○	○	○	○	○	○	○
22. **Mood?**	○	○	○	○	○	○	○	○	○	○
23. **Work (including work around the house)?**	○	○	○	○	○	○	○	○	○	○
24. **Relations with other people?**	○	○	○	○	○	○	○	○	○	○
25. **Walking?**	○	○	○	○	○	○	○	○	○	○
26. **Enjoyment of life?**	○	○	○	○	○	○	○	○	○	○

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