

Hindi Translation and Validation of the Manchester COPD Fatigue Scale: A Cross-sectional Study

SHIVI BAJPAI¹, MOUSUMI SAHA², SUBHASISH CHATTERJEE³, SHANVI PRIYA⁴,
AASMAN KUMARI⁵, ANUSHKA⁶, TAI YAYUM⁷, MRITUNJAY⁸



ABSTRACT

Introduction: The most common yet under-evaluated symptom in patients with Chronic Obstructive Pulmonary Disease (COPD) is fatigue which has significant implications for quality of life and functional status. To assess this multidimensional construct accurately a disease specific tool is essential. The Manchester COPD Fatigue Scale (MCFS) is a validated tool to measure fatigue but due to its unavailability in Hindi it cannot be put to use in the Indian population with COPD. So for that reason, the aim of the study is to translate it into Hindi language and validate it to ensure correct assessment of fatigue in Hindi speaking patients with COPD.

Aim: To systematically translate the MCFS into the Hindi language and evaluate its content validity in patients with COPD.

Materials and Methods: The present cross-sectional study was conducted at the Maharishi Markandeshwar Institute of Physiotherapy and Rehabilitation, Mullana, Ambala, Haryana,

India, from September 2025 to February 2026. The study was conducted by using a methodological design which included forward-backward translation and expert review by Delphi method to appropriately assess the clarity and conception of the translated version of the scale. The statistical analysis was done using the Item level Content Validity Index (I-CVI). The purpose of the current study is to create a Hindi version of this scale so, after the approval from the original developer, the authors created the Hindi version of the scale using a forward-backward translation process. Eight experts then evaluated the content validity of the scale.

Results: The Hindi version of the MCFS demonstrated excellent content validity with high item-level and scale-level content validity indices i.e., 0.97.

Conclusion: The Hindi version of the MCFS was successfully translated and demonstrated excellent content validity in Hindi speaking patients with COPD.

Keywords: Chronic obstructive pulmonary disease, Functional status, Humans, Language, Pulmonary disease, Quality of life

INTRODUCTION

The COPD has a major impact on healthcare costs and is associated with smoking and biomass smoke exposure. COPD leads to decline in the lung function with persistent progressive airflow limitation [1]. Symptoms like cough, phlegm and dyspnoea and clinical presentation varies according to different stages. Clinical, physiological and pathological heterogeneity of COPD hampers the effective treatment [2]. By 2050, it is estimated that COPD cases will reach up to 592 million among adults aged 25 or older and by 2030 it will become the third leading cause of death worldwide as estimated by World Health Organisation (WHO) in around 2005 although, the current data states that it is the fourth leading cause of the death, responsible for 3.5 million deaths alone in 2021[3]. The most common cause of high mortality rate across the globe is chronic inflammatory lung disease [4]. The prevalence of COPD among women are gradually increasing day by day with that of the men. The reason being is that the women are more likely to be exposed to other factors like biomass smoke etc., [5].

The COPD patients experience a broad range of pulmonary and extra pulmonary symptoms fatigue being one of them. Fatigue can be defined as the subjective and unpleasant feeling ranging from mild tiredness to severe exhaustion that can limit an individual's ability to carry out normal activities [3]. After dyspnoea, fatigue is the next symptom that a COPD patient experiences and it shows a major effect on the overall health status, quality of life and daily activities [6]. Due to fatigue there are some other associated symptoms like pain, dyspnoea, sleep disturbances, depression, anxiety, etc., that can be seen in COPD patients. The prevalence of fatigue in COPD patients ranges from 17% to 95% and 47% to

72% [7]. Fatigue also affects motivation, which results in decreased concentration of the patients and lack of ability to perform daily activities like household chores etc., [8].

Despite being one of the most important symptoms of COPD, there are very few questionnaires that are specifically designed to measure fatigue accurately. There are many general and often simple scales and questionnaires are there but they may not adequately measure the characteristics of fatigue specific to COPD [9]. Fatigue is the most common symptom that is present in other chronic diseases such as rheumatoid arthritis, multiple sclerosis etc., but in COPD it is uniquely associated with dyspnoea [10]. In COPD patients, fatigue is a usual feeling which is mostly due to any kind of exertional activity but in asthma patients, fatigue occurs due to the exacerbations which are intensified by exertion [11].

To address the gap of comprehensive assessment of fatigue in COPD patients, the MCFS was created into the Hindi language. The original scale has been translated into many different languages and then validated, is being used worldwide by many clinicians and researchers, and even gets recommended by international guidelines as a useful measure for the assessment of fatigue in COPD patients [9]. The MCFS has been proved to be a simple, reliable and valid tool to assess fatigue in the population of China with COPD [12]. The MCFS is found to be responsive to the effects of pulmonary rehabilitation in patients with COPD, and change in MCFS correlated with reduced dyspnoea and improved quality of life following pulmonary rehabilitation [13]. The main aim of this study was to translate the MCFS into Hindi language and evaluate its content validity by expert panel.

MATERIALS AND METHODS

The present cross-sectional observational study was held in Maharishi Markandeshwar Institute of Physiotherapy and Rehabilitation, Mullana, Ambala, Haryana, India, from September 2025 to February 2026. Ethical approval for the study was obtained from Institutional Ethical Committee (IEC), IEC-2595. The study was adhered to the World Medical Associations Helsinki Declaration, Council for International Organisations of Medical Sciences (CIOMS) International Ethical Guidelines, and the Indian Council of Medical Research National Ethical Guidelines. All the study participants signed the informed consent. The permission to use, translates, and validates the hindi version of MCFS was obtained from the primary developer of the scale.

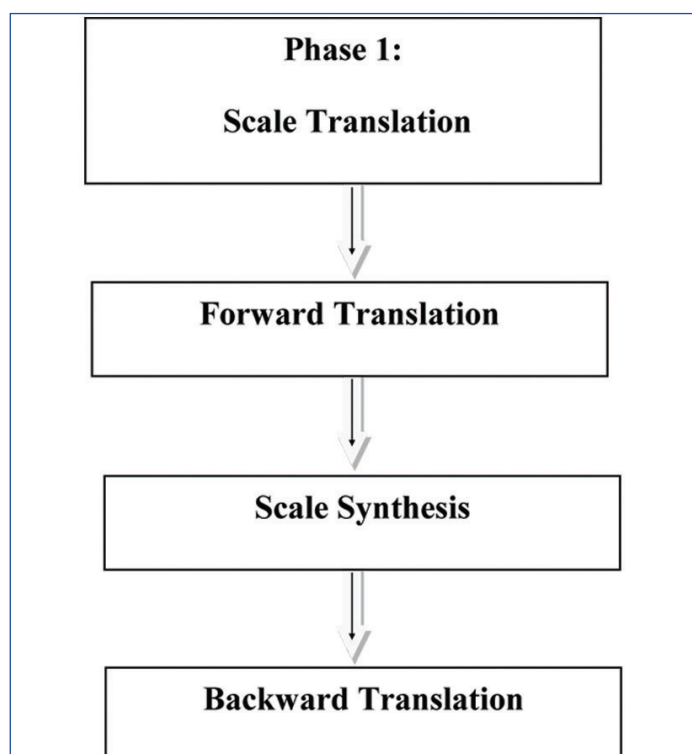
Inclusion and Exclusion criteria: Inclusion criteria include diagnosed cases of COPD as per the GOLD (Global Initiative for Chronic Obstructive Lung Disease) criteria [14], clinically stable patients (both male and female), patients who willingly wanted to participate in the study, Hindi-speaking populations whereas the exclusion criteria included patients with any kind of visual, cognitive or neurological impairments, any other chronic fatigue causing co-morbidities like uncontrolled hypothyroidism, advanced heart failure, chronic kidney disease, malignancies, etc., and non-Hindi speakers.

Sample size: As per the recommendations, a total of 51 patients with COPD were taken to assess the clarity and comprehensibility of the Hindi version of the MCFS. All these samples are a part of a larger study on the reliability analysis of the translated Hindi version of the MCFS. All the samples were taken through convenient sampling method.

Study Procedure

Phase 1: Scale Translation

The MCFS was translated into Hindi language with the permission from its original creators. The scale should ideally go through at least two forward translations from the source language to the chosen language at this point. In order to do this, two bilingual people-T1, who has a medical background and is familiar with the principles, and T2, who does not separately, translated the English scale into Hindi version while adhering to the guidelines [15]. The non-medical translator is aware of the true significance of the original scale [Table/Fig-1].



[Table/Fig-1]: Phase I - Process of translation of the scale (forward translation, synthesis, and backward translation).

Scale synthesis: The two translators and a recording bystander sat down together for the synthesis of the results of the restatements. Working from the primary scale also because the first translator's (T1) and thus the other translator's (T2) performances, a synthesis of those restatements is first conducted to produce one translated questionnaire with a report care completely establishing the conflation process, each of the addressed issues, and the way they were resolved. It is important that the agreement rather of one person's compromising his or her passions resolve issues. This phase is completed with this synthesised T-1,2 interpretation of the scale.

Backward translation: To carry forward this step, two bilingual individuals namely BT1 and BT2, who have a sound knowledge of both English and the targeted Hindi language, independently translated Hindi version i.e., T12 back into English to construct the translated English versions 1 and 2. This procedure was done for the validation of the translated version to make sure that it contains the same information as that of the original version. The most popular method of validity checking that identifies significant grammatical or linguistic errors in the translation is back translation. The topics that have already been mentioned were unfamiliar to these two translators. The major goal of this was to prevent the information bias. The back-translated version and the original MCFS were checked for any discrepancies that would point to ambiguous language in the source or mistakes made during the translation process. Beaton DE et al., guidelines served as the foundation for this study [16].

Phase 2: Content validity

Expert panel selection: The MCFS content validation relies on feedback from a review committee using an online Delphi approach. The evaluation of the content validity of the scale was done by the team of eight Delphi experts which includes physiotherapists, rehabilitation specialists, etc., who have an extensive clinical and academic experience in treating COPD patients in India. All the experts have reviewed the scale via Gmail, rating items as: 1) Not relevant; 2) Items needs revision; 3) Relevant but needs minor revision; 4) Very relevant. A four-point rating system is commonly used for the evaluation of the content validation. The expert's choices have guided the final documentation and rationale for the Hindi version of the scale [Table/Fig-2].

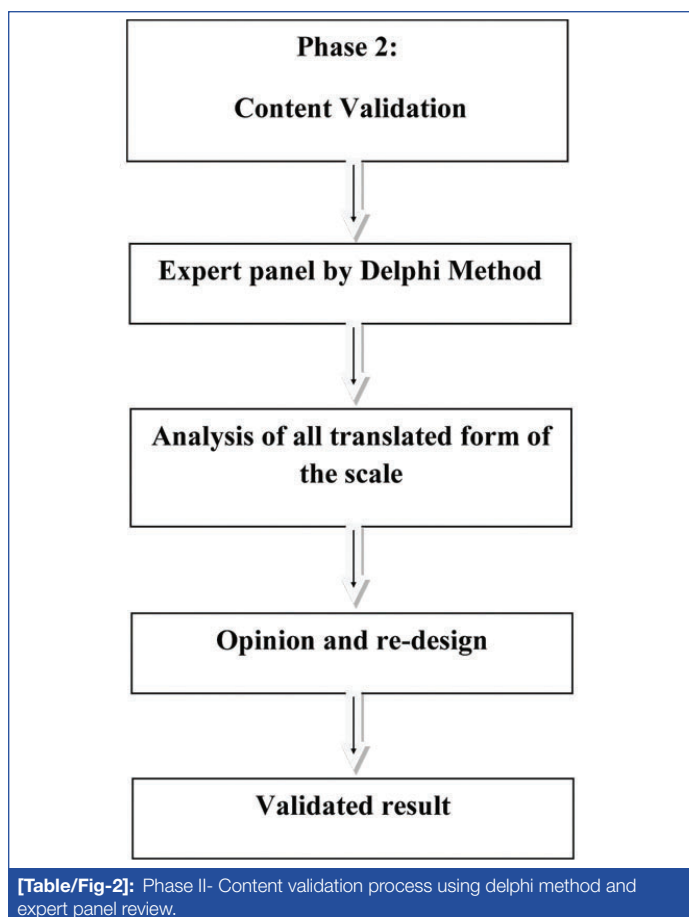
Content validity assessment: All the experts independently evaluated each item of the scale for simplicity, ambiguity, relevance and clarity. The I-CVI and Scale-level Content Validity Index (S-CVI) were calculated using a tabular format. The Delphi method used for the primary validation was through the email only. All the items were assessed with the I-CVI and S-CVI, using the averaging method (S-CVI/Ave) and Universal Agreement calculation (S-CVI/UA). Based on Lynn's (1986) criteria, for a group of eight review experts, the S-CVI/Ave should be at least 0.90 and the minimum I-CVI should be 0.78 for superior content validity [17,18]. Those items which were not up to the acceptable thresholds were revised or removed from the translated version of the scale after the consensus discussion.

The review by the expert panel demonstrated that all the agreements were excellent. They confirmed that the scale items have adequately represented the construct of fatigue in COPD patients.

Hindi Translated Version of the Manchester COPD Fatigue Scale (MCFS) is given in [Annexure-1].

STATISTICAL ANALYSIS

All the data were analysed using the IBM Statistical Package for the Social Sciences (SPSS) statistics version 26.0. The content validity was evaluated using the I-CVI. Eight experts were included who rated each item on a 4-point relevance scale. The rating 3 or 4 were considered relevant and the Scale-level CVI (S-CVI/Ave) was calculated as the average of all the I-CVI values [17]. All the



ratings with 3 and 4 were recorded as '1' while ratings with 1 and 2 were recorded as '0'. The I-CVI was calculated as the proportion of experts rating an item as relevant and the Scale-Level Content Validity Index (S-CVI/Ave) was calculated as the average of all I-CVI values. The S-CVI/UA was calculated as the proportion of items with universal agreement among experts.

RESULTS

A total of 51 patients with COPD were screened at our hospital and all were included in the study for data analysis. The translation process was completed using forward-backward procedures. There were some minor linguistic modifications that were made after the expert review to make sure the semantic and conceptual equivalence. The final Hindi version was found to be understandable and appropriate during the testing and so no major modifications were required. Eight experts were included in the content validation process. Each and every item of the scale achieved acceptable I-CVI values, the average S-CVI/Ave was 0.97, indicating strong expert agreement about the relevance and clarity. The overall S-CVI demonstrated excellent content validity [Table/Fig-3].

Proportion of items judged as relevance across the eight experts Average=0.97

DISCUSSION

The aim of the present study is to systematically translate the MCFS into the Hindi language and evaluate its content validity in patients with COPD. The findings provide strong evidence that the MCFS is a valid and multidimensional instrument for assessing fatigue in patients with COPD.

Items	Expert 1	Expert 2	Expert 3	Expert 4	Expert 5	Expert 6	Expert 7	Expert 8	Experts in agreement	I-CVI	UA
Q1	1	1	1	1	1	1	1	1	8	1	1
Q2	1	1	1	1	1	1	1	1	8	1	1
Q3	1	1	1	1	1	1	1	1	8	1	1
Q4	1	1	1	1	1	1	1	1	8	1	1
Q5	1	1	1	1	1	1	1	1	8	1	1
Q6	1	1	1	1	1	1	1	1	8	1	1
Q7	1	1	1	1	1	1	1	1	8	1	1
Q8	1	1	1	1	1	1	1	1	8	1	1
Q9	1	1	1	1	1	1	1	1	8	1	1
Q10	1	1	1	1	1	1	1	1	8	1	1
Q11	1	1	1	1	1	1	1	1	8	1	1
Q12	1	1	1	1	1	1	1	1	8	1	1
Q13	1	1	1	1	1	1	1	1	8	1	1
Q14	1	1	1	1	1	0	1	1	7	0.875	0
Q15	1	1	1	1	1	1	1	1	8	1	1
Q16	1	1	1	1	1	0	1	1	7	0.875	0
Q17	1	1	1	1	1	1	1	1	8	1	1
Q18	1	1	1	1	1	0	1	1	7	0.875	0
Q19	1	1	1	1	1	0	1	1	7	0.875	0
Q20	1	1	1	1	1	1	1	1	8	1	1
Q21	1	1	1	1	1	1	1	1	8	1	1
Q22	1	1	1	1	1	1	1	1	8	1	1
Q23	1	1	1	1	1	0	1	1	7	0.875	0
Q24	1	1	1	1	1	0	1	1	7	0.875	0
Q25	1	1	1	1	1	1	1	1	8	1	1
Q26	1	1	1	1	1	1	1	1	8	1	1
Q27	1	1	1	1	1	1	1	1	8	1	1
									SCVI/Ave	0.97	
Proportion relevance	1	1	1	1	1	0.7	1	1	SCVI/UA		0.78

[Table/Fig-3]: Item-wise Content Validity Index (I-CVI), Universal Agreement (UA), and Scale-level Content Validity Index (S-CVI) based on expert panel evaluation (n=8).

The fatigue is one of the most common yet under-recognised symptoms in COPD, but it is most often described by patients as constant, devastating and functionally limiting. In spite of its clinical significance, fatigue is not appropriately captured by many commonly used COPD outcome measures rather they tend to focus mainly on dyspnoea, airflow limitation and health status [19]. The MCFS was mainly translated into Hindi language to address this gap in patient-reported episodes of fatigue related to COPD by ensuring strong content relevance and disease specificity. The MCFS includes 27 items covering many fatigue-related parameters that supports the comprehensive nature of the scale and strengthen its content validity.

The primary strength of the study lies in the thorough translation process which includes forward-backward translation and expert panel evaluation. The inclusion of team of experts from relevant clinical backgrounds further strengthened the content validation by including both the theoretical and practical views related to COPD. After being translated into Hindi, the English version of the MCFS was validated by Delphi method. Specifically designed for COPD patients who experiences fatigue, this is the first translation of the fatigue assessment in COPD patients into the mother tongue of a significant portion of India. Only a few small linguistic errors occurred when translating the English version into Hindi, both forward and backward.

All the items of the scale got acceptable I-CVI values, demonstrating strong expert agreement about the relevance and clarity. The overall S-CVI demonstrated excellent content validity with a high S-CVI/Ave value of 0.97, which indicates strong agreement among all the experts about the relevance and aptness of the translated items of the scale. This also suggests that the Hindi version retains the actual and conceptual meaning of the original MCFS while being adapted to the target population.

In the Chinese version of the MCFS, a standardised forward - backward translation approach based on the established models was employed to ensure the conceptual and semantic basis across the languages. The expert panel assessment played an important role in refining the items and ensuring cultural relevance. The high content validity demonstrated in the present study is consistent with the translation frameworks used in the other translated versions thereby supporting the original construct of the scale [12].

The availability of a valid and reliable fatigue-specific measure is very important from a clinical and rehabilitation perspective. The exercise tolerance, physical activity participation, adherence to pulmonary rehabilitation and overall treatment outcomes have been shown to be significantly influenced by fatigue [20].

The strong psychometric properties of the MCFS supports its applicability in physiotherapy assessment, clinical trials and pulmonary rehabilitation programs, enabling therapists to identify fatigue-related limitations, monitor changes over time and tailor-made interventions more proficiently. Incorporating MCFS into routine clinical practice can also assist in more holistic symptom management and patient-centered care.

Limitation(s)

The present study has a limitation that should be taken into consideration. The study was done in a specific clinical setting

which may affect the generalisability of the results to broader Hindi-speaking populations.

CONCLUSION(S)

The Hindi version of the MCFS was successfully translated and demonstrated excellent content validity in Hindi-speaking patients with COPD. The multidimensional structure of the MCFS exhibits the complex nature of fatigue in COPD and strongly supports its use as a comprehensive tool for both clinical practice and research.

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PARTICULARS OF CONTRIBUTORS:

1. Postgraduate Student, Maharishi Markandeshwar Institute of Physiotherapy and Rehabilitation, Maharishi Markandeshwar (Deemed to be University), Mullana, Ambala, Haryana, India.
2. Assistant Professor, Maharishi Markandeshwar Institute of Physiotherapy and Rehabilitation, Maharishi Markandeshwar (Deemed to be University), Mullana, Ambala, Haryana, India.
3. Professor, Maharishi Markandeshwar Institute of Physiotherapy and Rehabilitation, Maharishi Markandeshwar (Deemed to be University), Mullana, Ambala, Haryana, India.
4. Postgraduate Student, Maharishi Markandeshwar Institute of Physiotherapy and Rehabilitation, Maharishi Markandeshwar (Deemed to be University), Mullana, Ambala, Haryana, India.
5. PhD Scholar, Department of Physiotherapy, Maharishi Markandeshwar Institute of Physiotherapy and Rehabilitation, Maharishi Markandeshwar (Deemed to be University), Mullana, Ambala, Haryana, India.
6. Postgraduate Student, Maharishi Markandeshwar Institute of Physiotherapy and Rehabilitation, Maharishi Markandeshwar (Deemed to be University), Mullana, Ambala, Haryana, India.
7. Postgraduate Student, Maharishi Markandeshwar Institute of Physiotherapy and Rehabilitation, Maharishi Markandeshwar (Deemed to be University), Mullana, Ambala, Haryana, India.
8. Postgraduate Student, Maharishi Markandeshwar Institute of Physiotherapy and Rehabilitation, Maharishi Markandeshwar (Deemed to be University), Mullana, Ambala, Haryana, India.

NAME, ADDRESS, E-MAIL ID OF THE CORRESPONDING AUTHOR:

Dr. Mousumi Saha,
Assistant Professor, Maharishi Markandeshwar Institute of Physiotherapy and Rehabilitation, Maharishi Markandeshwar (Deemed to be University), Mullana, Ambala-133207, Haryana, India.
E-mail: msaha0029@gmail.com

PLAGIARISM CHECKING METHODS: [Jain H et al.]

- Plagiarism X-checker: Mar 01, 2026
- Manual Googling: Jun 08, 2026
- iThenticate Software: Jun 10, 2026 (7%)

ETYMOLOGY: Author Origin**EMENDATIONS:** 6**AUTHOR DECLARATION:**

- Financial or Other Competing Interests: None
- Was Ethics Committee Approval obtained for this study? Yes
- Was informed consent obtained from the subjects involved in the study? Yes
- For any images presented appropriate consent has been obtained from the subjects. NA

Date of Submission: Feb 28, 2026

Date of Peer Review: Mar 18, 2026

Date of Acceptance: Jun 12, 2026

Date of Publishing: Sep 01, 2026

[ANNEXURE-1]

(Hindi Translated Version of the Manchester COPD Fatigue Scale)

मैनचेस्टर सीओपीडी-थकान पैमाना (MCFS)

लोग कभी-कभी सीओपीडी होने के कारण अत्यधिक थकान या थकावट का अनुभव करते हैं। 'सामान्य' थकान नींद और आराम से ठीक हो जाती है; जब यह ठीक नहीं होती, तो इसे कभी-कभी 'थकान' कहा जाता है।

हर कथन के बारे में अपनी पहली प्रतिक्रिया दें कि क्या यह आपके सीओपीडी और उससे जुड़ी थकान के अनुभव का वर्णन करता है (पिछले दो हफ्तों के अनुभव को ध्यान में रखते हुए)। निर्णय लेने में ज्यादा समय न लें।

हर कथन का उत्तर दें। यदि आपको लगता है कि कोई कथन आपके लिए लागू नहीं है, तो भी 'कभी नहीं' (Never) का उत्तर दें।

यहाँ कोई सही या गलत उत्तर नहीं है।

पिछले 2 हफ्तों में अपनी थकान के बारे में सोचते हुए... प्रत्येक कथन का उत्तर दें।

उत्तर विकल्प:

कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा

1. थकान के कारण मैं घर के बाहर की सामाजिक गतिविधियों को सीमित करता/करती हूँ।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा

2. हल्का सामान उठाना (जैसे एक बैग खरीदारी का) मुझे थका देता है।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा

3. मैं ऊपर चढ़ने या सीढ़ियाँ चढ़ने से बचता/बचती हूँ क्योंकि मैं थक जाऊँगा/जाऊँगी।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा

4. मैं हल्का भार (जैसे टर्नली या इलेक्ट्रिक लॉन मोवर को समतल ज़मीन पर धकेलना) धकेलने से बचता/बचती हूँ क्योंकि इससे मैं पूरी तरह थक जाता/जाती हूँ।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा

5. व्यायाम शुरू करने से पहले ही मुझे थकान महसूस होती है।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा

6. जब मैं कचरा बाहर फेंकता/फेंकती हूँ तो थकान महसूस होती है।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा

7. घर से कार या बस तक (लगभग 50 मीटर) चलने से मुझे थकान होती है।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा

8. थकान के कारण मुझे स्पष्ट रूप से सोचना कठिन लगता है।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा

9. थकान के कारण मेरा ध्यान केंद्रित करना कठिन हो जाता है।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा

10. जब मैं कोई शारीरिक गतिविधि करना चाहता/चाहती हूँ, तो मुझे ऊर्जा की कमी महसूस होती है।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा

11. मेरी थकान मुझे निराश कर देती है।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा

12. जब मैं थका/थकी होता/होती हूँ, तो मैं ऊब जाता/जाती हूँ।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा

13. मेरी थकान मुझे उदास कर देती है।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा

14. मेरी थकान मुझे वे काम करने से रोकती है जिन्हें मैं पसंद करता/करती हूँ।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा

15. थकान के कारण मेरे पैर भारी महसूस होते हैं।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा
16. थकान के कारण मैं काम करने में काफी धीमा/धीमी हो जाता/जाती हूँ।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा
17. मेरी थकान मुझे परेशान करती है।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा
18. थकान के कारण मैं दूसरों की तुलना में सोचने में धीमा/धीमी हो जाता/जाती हूँ।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा
19. मैं उनींदा महसूस करता/करती हूँ।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा
20. थकान के कारण मेरा पहले जैसा उत्साह कम हो गया है।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा
21. मैं सुस्त (लेटर्जिक) महसूस करता/करती हूँ।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा
22. थकान के कारण मैं कमजोर महसूस करता/करती हूँ।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा
23. मुझे चिंता होती है कि अन्य लोग मेरी थकान के बारे में क्या सोचते हैं।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा
24. कुल मिलाकर, मेरी थकान मेरे कर्तव्यों और जिम्मेदारियों को निभाने में बाधा डालती है।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा
25. कुल मिलाकर, थकान मेरे लिए समस्याएँ पैदा करती है।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा
26. अपनी थकान के कारण मैं अब पहले की तरह जीवन में भाग नहीं ले सकता/सकती हूँ।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा
27. कोई गतिविधि बार-बार करने से (जैसे कुर्सी से उठना-बैठना, बगीचे में काम करना या वॉशिंग मशीन में कपड़े डालना और निकालना) मैं थक जाता/जाती हूँ।
कभी नहीं / शायद ही कभी / कभी-कभी / अक्सर / हमेशा