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Login

Select English

Welcome to symptomskema.dk

Symptomskema.dk is part of the national clinical registry for people with a functional disorder.
To read more about the purpose of the registry, click on the **Information** button.

Go to the questionnaire: Click on Login using NemID to access the questionnaire.
If you do not have a NemID: Click on I do not have NemID. Then click on the white field and enter your CPR number and click "Login".
(All information is sent via a secure and encrypted connection).

Login using NemID

I do not have NemID

Information **Withdraw consent**

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Welcome

Test Patient

Select English

Welcome to symptomskema.dk

In order to provide you with the most appropriate treatment in the Center for Functional Disorders, it is necessary for us to know more about your situation. We therefore ask you to complete this questionnaire before your first appointment in the center. It takes approx. 30 minutes to complete the questionnaire. You can log in to the questionnaire several times if you do not want to complete the entire questionnaire at once.

It is our experience that a functional disorder can affect both mood, work life and social relationships. We therefore ask many different questions and we ask you to answer all the questions as good as you can. The information from the questionnaire is used together with the clinical interview in the center to plan the treatment as good as possible for your current situation.

We will also ask you to complete a questionnaire, immediately after your treatment in the center is completed.

All information collected via the questionnaire is confidential and subject to professional secrecy. Information is only used in connection with your course of treatment in the center and is not passed on to others. If you wish, you have the right to see the information collected and the right to have any wrong information corrected. You also have the right to have the processing of your information restricted and to complain to the Danish Data Protection Agency about the processing of your information. If you wish to see the information collected about you, have it corrected or use your right to restrict the processing of your information in connection with your treatment, please contact the center to which you are referred.

Tap on the **next** button in the bottom right corner to start the questionnaire.

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CONSENT TO QUALITY DEVELOPMENT AND RESEARCH

We want your consent to use your information from this questionnaire, and to pass on information from your patient record to:

The National Quality and Research Database for People with a Functional Disorder (FunkData)

The 5 centers in Denmark (Center for Functional Disorders, Region of Southern Denmark; Functional Disorders, Central Denmark Region; Center for Functional Disorders, The North Denmark Region; Center for Functional Disorders, Region Zealand and Center for Complex Symptoms, Capital Region of Denmark) work together to improve the future treatment through the establishment of a quality and research database, which will form the basis for specific quality development projects and research projects within research and treatment.

We therefore ask for your permission to use the information you enter in the questionnaire via www.symptomskema.dk for this purpose.

We will also ask for your consent for the following information to be passed on from your patient record, from the center to which you are referred, to the Quality and Research Database:

- Clinical examination
- Diagnosis
- Medicine
- Treatment

Data Processing

All information is confidential and subject to professional secrecy. Information from the database can only be used in research projects within the same purpose as described above, which have the formal approvals of public authorities. In addition, the information can be used for specific quality development projects, which are carried out locally in the centers, which are part of this collaboration.

How we use your information: The information is processed in accordance with the Data Protection Regulation art. 6 pieces. 1, letter a and art. 9, para. 2, letter a, which are the rules on consent.

Deleting and storing your data: We will delete or anonymize data when it is no longer relevant to store your personal information.

Please note: Information from the questionnaire is used in your course of treatment in the center and is not passed on to others. If you wish, you have the right to see the information collected from the questionnaire and the right to have any wrong information corrected. You also have the right to have the processing of your information restricted and to complain to the Danish Data Protection Agency about the processing of your information. If you want to see the information collected about you, have it corrected or use your right to limit the processing of your information in connection with your treatment process, please contact Center for Functional Disorders, Region of Southern Denmark who is the database manager on telephone 65413869.

Additional Information

The processing and storage of personal data takes place in accordance with the Data Protection Ordinance and the Data Protection Act. If you have questions about the Region of Southern Denmarks processing of your information, you are always welcome to contact the Region of Southern Denmarks data protection adviser via your digital mailbox (borger.dk or e-boks.dk). You can also send an e-mail to databeskyttelsesraadgiver@rsyd.dk. Questions about the database should be directed to Henrik Bjarke Vægter (responsible for the database) or the chief physician at the Center for Functional Disorders, Region of Southern Denmark

The Center for Functional Disorders, Odense University Hospital is responsible for the database, which has been approved by the Danish Data Protection Agency. Database manager: Henrik Bjarke Vægter, Pain Center South / Center for Functional Disorders, Odense University Hospital

Whether you give us your permission or not, it will not affect your course of treatment at the center. If you regret having given your permission, you can revoke your consent at any time via www.symptomskema.dk og by contacting Center for Functional Disorders, Odense University Hospital on telephone 65 41 38 69. The collection of data about you for use in quality assurance and research will then cease.

Participant Statement

I hereby confirm that I have received sufficient information about the content, purpose, method of the database, including what types of information are passed on from my patient record to the database, as well as what this information is to be used for and how it is processed. I know that participation is voluntary and that I can always withdraw my consent without losing my current or future rights to treatment.

The consent ceases no later than one year after it has been submitted, after which you will again be asked if you want to give your consent to the transfer of your information for use in the database. The fact that a consent is ceased or not desired to be extended does not mean that already passed on information must be deleted from the database.

I hereby give my consent for the answers I have given in the questionnaires to be passed on to the quality and research database. — No / Yes

I hereby give my consent for the above information from my patient record to be passed on for use in the database. — No / Yes

I hereby give my consent for the center to which I am referred, to contact me in relation to future projects where my participation may be relevant to me. — No / Yes

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Contact information

Test Patient

Select English

Enter your contact information below. Your contact information will ONLY be used in connection with direct contact from the Center for Functional Disorders, and your contact information will not be passed on to others.

E-mail

Mobile phone number

Do you have e-boks?

No | Yes

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Physical symptoms from heart and lungs

Test Patient

Select English

On the following pages, we want information on the extent to which you have been bothered by various symptoms.

During the last 4 weeks, have you been bothered by:

Palpitations or heart pounding?	Not at all	A bit	Somewhat	Quite a bit	A lot
Precordial discomfort?	Not at all	A bit	Somewhat	Quite a bit	A lot
Breathlessness without exertion?	Not at all	A bit	Somewhat	Quite a bit	A lot
Hyperventilation?	Not at all	A bit	Somewhat	Quite a bit	A lot
Hot or cold sweats?	Not at all	A bit	Somewhat	Quite a bit	A lot
Dry mouth?	Not at all	A bit	Somewhat	Quite a bit	A lot

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Physical symptoms from stomach and intestines

Test Patient

Select English

During the last 4 weeks, have you been bothered by:

	Not at all	A bit	Somewhat	Quite a bit	A lot
Frequent loose bowel movements?					
Abdominal pains?					
Feeling bloated/full of gas/distended?					
Diarrhoea?					
Regurgitations?					
Nausea?					
Burning sensation of the chest or upper part of stomach/epigastrium?					

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Physical symptoms from muscles and joints

Test Patient

Select English

During the last 4 weeks, have you been bothered by:

	Not at all	A bit	Somewhat	Quite a bit	A lot
Pains in arms or legs?					
Muscular aches or pains?					
Pains in the joints?					
Feeling of paresis or localised weakness?					
Backache?					
Pain moving from one place to another?					
Unpleasant numbness or tingling sensations?					

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General symptoms

Test Patient

Select English

During the last 4 weeks, have you been bothered by:

	Not at all	A bit	Somewhat	Quite a bit	A lot
Concentration difficulties?					
Excessive fatigue?					
Headache?					
Impairment of memory?					
Dizziness?					

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Symptom onset

Test Patient

Select English

Here we want information about how long (approximately) you have experienced your symptoms. Press + or - next to day, month or year to activate the calendar. Then indicate when your symptoms started using the + or - symbols.

Approximately when was the onset of your symptoms?

-		+	-		+	-		+
	day			month			year	

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Symptom intensity and interference

Test Patient

Select English

On this page we want information about the intensity of your symptoms, as well as how much your symptoms affect your daily activities.

During the last 7 days, the overall intensity of my symptoms was:

No symptoms at all — Worst possible symptoms

0 1 2 3 4 5 6 7 8 9 10

During the last 7 days, my bodily symptoms interfered with daily life activities:

Not at all — Interfered completely

0 1 2 3 4 5 6 7 8 9 10

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Symptom interference

Test Patient

Select English

On this page we want information about the extent to which your symptoms interfere with your work/daily tasks, your social life/leisure activities and your family life/home responsibilities.

Check ONE box for each question. All responses should refer to the last 14 days.

WORK / DAILY TASKS: The symptoms have disrupted your work / daily tasks

Not at all — Extremely

0	1	2	3	4	5	6	7	8	9	10

SOCIAL LIFE: The symptoms have disrupted your social life / leisure activities

Not at all — Extremely

0	1	2	3	4	5	6	7	8	9	10

FAMILIY LIFE / HOME RESPONSIBILITIES: The symptoms have disrupted your family life / home responsibilities

Not at all — Extremely

0	1	2	3	4	5	6	7	8	9	10

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General health

Test Patient

Select English

The following questions are about your perception of your general health. The information will provide an overview of how you are feeling and how well you are able to perform your daily tasks and activities.

In general, would you say your health is:

Excellent	Very Good	Good	Fair	Poor

Compared to one year ago, how would you rate your health in general now? :

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same
- Somewhat worse now than one year ago
- Much worse than one year ago

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Limitations of activities

Test Patient

Select English

Does your health now limit you in these activities? If so, how much?

	Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited at all
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports			
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf			
Lifting or carrying groceries			
Climbing several flights of stairs			
Climbing one flight of stairs			
Bending, kneeling, or stooping			

Walking more than a kilometer	Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited at all
Walking several 100 meters	Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited at all
Walking 100 meter	Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited at all
Bathing or dressing yourself	Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited at all

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Physical health problems

Test Patient

Select English

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little bit of the time	None of the time
Cut down the amount of time you spent on work or other activities					
Accomplished less than you would like					
Were limited in the kind of work or other activities					
Had difficulty performing the work or other activities (for example, it took extra effort)					

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Emotional health problems

Test Patient

Select English

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

Cut down the amount of time you spent on work or other activities	All of the time	Most of the time	Some of the time	A little bit of the time	None of the time
Accomplished less than you would like	All of the time	Most of the time	Some of the time	A little bit of the time	None of the time
Didnt do work or other activities as carefully as usual	All of the time	Most of the time	Some of the time	A little bit of the time	None of the time

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Social activities

Test Patient

Select English

During the last 4 weeks, emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all	Slightly	Moderately	Severely	Very Severely

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Pain

Test Patient

Select English

How much bodily pain have you had during the past 4 weeks? :

- None
- Very Mild
- Mild
- Moderate
- Severe
- Very Severe

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	Slightly	Moderately	Severely	Very Severely

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Energy and emotions

Test Patient

Select English

These questions are about how you feel and how things have been with you during the last 4 weeks. For each question, please give the answer that comes closest to the way you have been feeling.

	All of the time	Most of the time	Some of the time	A little bit of the time	None of the time
Did you feel full of pep?					
Have you been a very nervous person?					
Have you felt so down in the dumps that nothing could cheer you up?					
Have you felt calm and peaceful?					
Did you have a lot of energy?					

Have you felt downhearted and blue?	All of the time	Most of the time	Some of the time	A little bit of the time	None of the time
Did you feel worn out?	All of the time	Most of the time	Some of the time	A little bit of the time	None of the time
Have you been a happy person?	All of the time	Most of the time	Some of the time	A little bit of the time	None of the time
Did you feel tired?	All of the time	Most of the time	Some of the time	A little bit of the time	None of the time

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Social activities

Test Patient

Select English

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little bit of the time	None of the time

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General health

Test Patient

Select English

How true or false is each of the following statements for you?

	Definitely true	Mostly true	Do not know	Mostly false	Definitely false
I seem to get sick a little easier than other people					
I am as healthy as anybody I know					
expect my health to get worse					
My health is excellent					

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Concerns about your illness and health

Test Patient

Select English

On this page, we want information on the extent to which you during the last 4 weeks, have been bothered by:

	Not at all	A little bit	Moderately	Quite a bit	A great deal
Worries that there is something seriously wrong with your body?					
Worries that you suffer a disease you have read or heard about?					
Worries about the possibility of having a serious illness?					
Thoughts, that the doctor may be wrong if telling you not to worry?					
Worries about your health?					
Recurrent thoughts about being ill that are difficult to get off your mind?					

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Symptoms of anxiety and depression

Test Patient

Select English

On the next pages, we want information on the extent to which you during the last 4 weeks, have been bothered by the following:

Feeling suddenly scared for no reason?	Not at all	A little bit	Moderately	Quite a bit	A great deal
Nervousness or shakiness inside?	Not at all	A little bit	Moderately	Quite a bit	A great deal
Spells of terror or panic?	Not at all	A little bit	Moderately	Quite a bit	A great deal
You worry too much?	Not at all	A little bit	Moderately	Quite a bit	A great deal
Feeling fearful?	Not at all	A little bit	Moderately	Quite a bit	A great deal

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Symptoms of anxiety and depression

Test Patient

Select English

During the last 4 weeks, have you been bothered by:

Feeling hopeless about the future?	Not at all	A little bit	Moderately	Quite a bit	A great deal
Feeling everything is an effort?	Not at all	A little bit	Moderately	Quite a bit	A great deal
Feeling blue?	Not at all	A little bit	Moderately	Quite a bit	A great deal
Feelings of worthlessness?	Not at all	A little bit	Moderately	Quite a bit	A great deal
Thoughts of ending your life?	Not at all	A little bit	Moderately	Quite a bit	A great deal

Feelings of being trapped or caught?

Not at all	A little bit	Moderately	Quite a bit	A great deal

Feeling lonely?

Not at all	A little bit	Moderately	Quite a bit	A great deal

Blaming yourself for things?

Not at all	A little bit	Moderately	Quite a bit	A great deal

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Thoughts about your symptoms

Test Patient

Select English

On the next pages, we want information about your thoughts and experiences related to your symptoms.

For each question, please choose the number between 0 and 10 that best matches your thoughts and experiences at the moment.

How much do your symptoms affect your life?

No affect at all — Severely affects my life

0 1 2 3 4 5 6 7 8 9 10

How long do you think your symptoms will continue?

A very short time — Forever

0 1 2 3 4 5 6 7 8 9 10

How much control do you feel you have over your symptoms?

Absolutely no control — Extreme amount of control

0 1 2 3 4 5 6 7 8 9 10

How much do you think the treatment can help your symptoms?

Not at all — Extremely helpful

0 1 2 3 4 5 6 7 8 9 10

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Thoughts about your symptoms

Test Patient

Select English

For each question, please choose the number between 0 and 10 that best matches your thoughts and experiences at the moment.

How concerned are you about your symptoms?

Not at all concerned — Extremely concerned

0 1 2 3 4 5 6 7 8 9 10

How well do you feel you understand your symptoms?

Do not understand at all — Understand very clearly

0 1 2 3 4 5 6 7 8 9 10

How much do your symptoms affect you emotionally? (e.g. do they make you angry, scared, upset or depressed?)

Not at all affected — Extremely affected

0 1 2 3 4 5 6 7 8 9 10

How likely do you think it is that you will recover completely?

Not likely at all — Extremely likely

0 1 2 3 4 5 6 7 8 9 10

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Thoughts about your symptoms

Test Patient

Select English

Would you describe your problem as: :

- Physical illness alone
- Mental distress
- Both physically and mentally
- Other things

I know exactly what is wrong with me

No, not at all — Yes, very clearly

0	1	2	3	4	5	6	7	8	9	10

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Thoughts about your symptoms

Test Patient

Select English

Please list in rank-order the three most important factors that you believe caused your symptoms.

1st cause

2nd cause

3rd cause

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Behavioural responses to your symptoms

Test Patient

Select English

On the following pages, we want information on how to manage your symptoms.

The statements below are about things you may or may not have done to manage your symptoms. Indicate how often you have done the following during the last 4 weeks.

	Not at all	Rarely	Some days	Most days	Every day
I have avoided physical exercise					
I have overdone things, then needed to rest up for a while					
I have put parts of my life on hold					

I have pushed myself as hard as ever until I can not push myself any more

Not at all	Rarely	Some days	Most days	Every day

I have avoided my usual activities

Not at all	Rarely	Some days	Most days	Every day

I have carried on with things as normal until my body can not cope any longer

Not at all	Rarely	Some days	Most days	Every day

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Behavioural responses to your symptoms

Test Patient

Select English

On the following pages, we want information on how to manage your symptoms.

The statements below are about things you may or may not have done to manage your symptoms. Indicate how often you have done the following during the last 4 weeks.

	Not at all	Rarely	Some days	Most days	Every day
I have gone to bed during the day					
I have felt obliged to carry out all my responsibilities, no matter how bad I feel					
I have tried to do too much and felt even worse as a result					

I have not been able to carry on with my usual level of activity	Not at all	Rarely	Some days	Most days	Every day
I haven't slowed down, I've just carried on as normal	Not at all	Rarely	Some days	Most days	Every day
I have taken time out from my usual activities so that I can get back to normal quicker	Not at all	Rarely	Some days	Most days	Every day
I find myself rushing to get everything done before I crash	Not at all	Rarely	Some days	Most days	Every day

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Height and weight

Test Patient

Select English

What is your height? (cm)

What is your weight? (kg)

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Family relationships

Test Patient

Select English

The following questions are about your family relationship.

I live with my spouse / partner / boyfriend / girlfriend — No | Yes

I live with children under 16 years of age — No | Yes

I live with others aged 16 or over — No | Yes

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Education

Test Patient

Select English

The following question is about your education.

What is your highest completed level of education? :

- Primary school education
- Upper secondary education
- Vocational Education and Training
- Short cycle higher education
- Vocational bachelors educations
- Masters programs

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Working life

Test Patient

Select English

The following questions are about your work life.

Which statement best suits your current work situation? :

- Working
- Part-time sick leave
- Full-time sick leave
- Unemployed
- Subsidised job
- Sick leave from subsidised job
- Disability pension
- Pension
- Student
- Other type of public support

How many years have you been in the labor market (including periods where you have been on sick leave from your job)?

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Smoking, alcohol and drugs

Test Patient

Select English

Do you smoke? :

- Yes, every day
- Yes, at least once a week
- Yes, but less often than every week
- No, I stopped
- No, I have never smoked

Has anyone in the last 12 months mentioned that you drink too much?

No | Yes

Has anyone in the last 12 months mentioned that you smoke too much cannabis or take other drugs?

No | Yes

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