

Child's Name:

Date:

Relationship to child:

Please respond to each question or statement by marking one box per row.

*In the past 7 days... how much trouble does your child have...*

1. My child could do sports and exercise that other kids his/her age could do...

With no trouble	With a little trouble	With some trouble	With a lot of trouble	Not able to do
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. My child could get up from the floor

With no trouble	With a little trouble	With some trouble	With a lot of trouble	Not able to do
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. My child could walk upstairs without holding on to anything

With no trouble	With a little trouble	With some trouble	With a lot of trouble	Not able to do
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. My child has been physically able to do the activities he/she enjoys most

With no trouble	With a little trouble	With some trouble	With a lot of trouble	Not able to do
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*In the past 7 days...*

5. My child felt accepted by other kids his/her age

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. My child was able to count on his/her friends

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. My child and his/her friends helped each other out

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Other kids wanted to be my child's friend

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. My child felt like something awful might happen...

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. My child felt nervous

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*In the past 7 days...*

11. My child felt worried...

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. My child worried when he/she was at home ...

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. My child felt everything in his/her life went wrong

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. My child felt lonely....

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. My child felt sad...

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*In the past 7 days...*

16. It was hard for my child to have fun

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. Being tired made it hard for my child to keep up with schoolwork...

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. My child got tired easily

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. My child was too tired to do sports or exercise

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. My child was too tired to enjoy the things he/she likes to do

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*In the past 7 days...*

21. My child had difficulty falling asleep

Never	Almost never	Sometimes	Almost always	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. My child slept through the night

Never	Almost never	Sometimes	Almost always	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23. My child had a problem with his/her sleep

Never	Almost never	Sometimes	Almost always	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24. My child had trouble sleeping

Never	Almost never	Sometimes	Almost always	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. My child had trouble sleeping when he/she had pain

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*In the past 7 days...*

26. It was hard for my child to pay attention when he/she had pain

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27. It was hard for my child to run when he/she had pain

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. It was hard for my child to walk one block when he/she had pain

Never	Almost never	Sometimes	Often	Almost always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. In the past 7 days, how bad was your pain on average?

<i>None</i>				<i>to</i>					<i>worst possible pain</i>	
0	1	2	3	4	5	6	7	8	9	10
<hr/>										