

A1. Site/Study ID #: ____ / ____

A2. Date: ____ / ____ / ____
Month Day Year

A3. Study Staff ID/Initials: ____

A4. Age: ____ yr

To DCC

A5. This form is to be completed by a subject's parent(s) or guardian(s). Please indicate below the primary source of information for this form (check all that apply):

a. Motherb. Fatherc. Guardian(s)d. Other (Specify: _____)**SECTION B: PEDSQL FOR YOUNG CHILDREN****DIRECTIONS:**

Below and on the following page are lists of things that might be a problem for **your child**. Please tell us **how much of a problem** each one has been for **your child** during the **past ONE month** by checking:

0 if it is **never** a problem1 if it is **almost never** a problem2 if it is **sometimes** a problem3 if it is **often** a problem4 if it is **almost always** a problem

There are no right or wrong answers. If you do not understand a question, please ask for help.

In the past **ONE month**, how much of a **problem** has **your child** had with...

	Never	Almost Never	Sometimes	Often	Almost Always
PHYSICAL FUNCTIONING (problems with...)					
B1. Walking more than one block	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B2. Running	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B3. Participating in sports activity or exercise	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B4. Lifting something heavy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B5. Taking a bath or shower by him or herself	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B6. Doing chores, like picking up his or her toys	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B7. Having hurts or aches	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B8. Low energy level	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
EMOTIONAL FUNCTIONING (problems with...)					
B9. Feeling afraid or scared	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B10. Feeling sad or blue	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B11. Feeling angry	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B12. Trouble sleeping	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B13. Worrying about what will happen to him or her	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

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In the past **ONE month**, how much of a **problem** has **your child** had with...

	Never	Almost Never	Sometimes	Often	Almost Always
SOCIAL FUNCTIONING (problems with...)					
B14. Getting along with other children	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B15. Other kids not wanting to be his or her friend	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B16. Getting teased by other children	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B17. Not able to do things that other children his or her age can do	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B18. Keeping up when playing with other children	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
SCHOOL FUNCTIONING (problems with...)					
B19. Paying attention in class	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B20. Forgetting things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B21. Keeping up with school activities	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B22. Missing school because of not feeling well	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B23. Missing school to go to the doctor or hospital	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4